

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09046

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK	c. LENGTH OF STAY IN 1b 7 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	d. COUNTY Fredrick		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK Mem.	e. STREET ADDRESS /	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CASANDRA	First L	Middle YNN	Last AUHerman		
4. DATE OF DEATH August 4 1958	Month	Day	Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Jy 1958		
9. AGE (In years lost birthday) yr. 7	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 7	Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? —		
13. FATHER'S NAME DONALD Leroy Auherman	14. MOTHER'S MAIDEN NAME PAULINE FRANCES CRUMMITT				
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Hosp. Record	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) Md.	(State) Md.
21. I certify that I attended the deceased from 28 Jy 1958 , to 4 August 1958 , that I last saw the deceased alive on 4 August 1958 , and that death occurred at 4 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE R.L. Guest	M.D.		ADDRESS (Street, city or town, state) 7 E. Church St.	DATE SIGNED 4 Aug 58	
PHYSICIAN'S NAME (Type) DR. R. L. GUEST	Frederick, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-5-58	22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVE Cemetery	22d. LOCATION (City, town or county) Frederick - Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son, Frederick Md.	W. ADDRESS 2069171 XV2	24a. REC'D BY REGISTRAR DATE AUG 6 '58	24b. REGISTRAR'S SIGNATURE John E. Cline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEVADA
DEPARTMENT OF MOTOR VEHICLES

CERTIFICATE OF DEATH

Death certificate
Number 12131397
Date 2/22/79
Place of death
So + Tropic
2 8291 YLS 2 2 3

Witnessed by (Signature) *John J. Morris* (Name of witness)
Address *1000 N. Las Vegas Rd.*

(Signature)
J. Morris

82 Tropic 2 82 4285

Death Address
1000 N. Las Vegas Rd.

82 Tropic +
1000 N. Las Vegas Rd.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9049

CERTIFICATE OF DEATH

Reg. Dist. No.

69047

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS Evergreen Point	
3. NAME OF DECEASED (Type or print)	First VAN	Middle OSCAR	Last BROWN
4. DATE OF DEATH	Month August	Day 26,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1890
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY Band	11. BIRTHPLACE (State or foreign country) Michigan
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. ?	17. INFORMANT Mrs. Della M. Brown—Same as Item #2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Chronic obstructive arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 26, 1953, to Aug. 26, 1958, that I last saw the deceased alive on Aug. 26, 1958, and that death occurred at 11:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Rex R. Martin</i> East Church Street DATE SIGNED 5/28/58			
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 30, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE SEP 3 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Lewis</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DEPARTMENT OF DEFENSE STATEMENT

REF ID: A65760

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9050

CERTIFICATE OF DEATH

69048

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All his certificate has been signed by the attending physician and completely filled in by the funeral director. His certificate may be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Frederick</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>6 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>		d. STREET ADDRESS <i>104 South Market</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>SUSAN Veronica</i>		First	Middle	Last	4. DATE OF DEATH <i>August 9</i>	Month	Day	Year
5. SEX <i>F</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 9/58</i>	9. AGE (In years last birthday) yrs. <i>1</i>	IF UNDER 1 YEAR Months <i>6</i>	IF UNDER 24 HRS. Days <i>25</i>	Hours Min. <i>00 00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Rolando D. Carey</i>		14. MOTHER'S MAIDEN NAME <i>Betty J. Shultz</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mother</i>		Address <i>Same</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fetal Asphyxia</i>		DUE TO <i>762.5</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i>		
		Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost.		DUE TO <i>Prematurity + Immaturity</i>				
		DUE TO <i>(c)</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>220 N. Market St.</i>		(County) <i>Frederick</i> (State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>9 August 1958</i> to <i>9 Aug 58</i> , 1958, that I last saw the deceased alive on <i>9 Aug 58</i> , 1958, and that death occurred at <i>11 1/2 M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <i>9 Aug 58</i>		
ACTUAL SIGNATURE <i>A. M. Powell, Jr.</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>A. M. Powell, Jr.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-12-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Frederick Memorial Park</i>		22d. LOCATION (City, town, or county) <i>Frederick, Maryland</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison & Son, Frederick, Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>AUG 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		

БІЗОНІДАЛАНДІРВАНЫҢ ОГЕСІНДЕ БІРЛІКТЕ СІМДЕМІ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9078 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09049

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained far your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the information prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Robert	Middle Ralph	Last Coffman	4. DATE OF DEATH Month August Day 2 Year 19 58
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1919	9. AGE (In years long month day) 30 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Guy E. Coffman		14. MOTHER'S MAIDEN NAME Phoebe Zella		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 213-18-9232		17. INFORMANT Mrs. Ella W. Coffman Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<i>Gun shot wound of half skull - Self inflicted</i>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour 1:00 A.M. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>B.O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. B.O. Thomas					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-58		22c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Maryland		24a. REC'D BY REGISTRAR DATE AUG 5 '58	
				24b. REGISTRAR'S SIGNATURE <i>Al Creager</i>	

WILCOX FARMING CO. INC.
11000 STATE HIGHWAY 90
MURKIN, TEXAS 75148

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9079

CERTIFICATE OF DEATH

Reg. Dist. No.

09050

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		b. COUNTY		
Frederick		MARYLAND		Maryland		Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Cullen		14+14 days		149 S. Mulberry St. Hagerstown		21x-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Victor Cullen State Hosp.						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Clarence Evers		CRAWFORD		August	21	19	58	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years at birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9/18/1904	53	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Fireman		Railroad		Maryland		U. S. A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address				
John D. Crawford		Anna Stine						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT				
No		213-16-0046		Hospital Chart				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Far Advanced Bilateral Active Tubercu-		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.				
002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		losis						
DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 10-7-54, 19, to 8-21-, 1958, that I last saw the deceased alive on 8-20, 1958, and that death occurred at 4:30 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					DATE SIGNED	
ACTUAL SIGNATURE	<i>T. F. Vestal</i>					M.D.	Victor Cullen State Hosp., Cullen, Maryland.	
PHYSICIAN'S NAME (Type)	T. F. Vestal, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM			22d. LOCATION (City, town, or county)			
Burial	8-23-58	Rose Hill Cemetery			Hagerstown, Wash. Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
A. K. Coffman, 40 E. Antietam St., Hagerstown, Md.				DATE AUG 22 '58		Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9051

CERTIFICATE OF DEATH

Reg. Dist. No.

69051

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 245 W. Patrick St.		d. STREET ADDRESS 103 W. 4th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Carl	Middle Clark	Last Cromwell	4. DATE OF DEATH	Month August	Day 3	Year 1958
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-1893	9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard C. Cromwell				14. MOTHER'S MAIDEN NAME Emma Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 217-12-1174		17. INFORMANT Mrs. Marion C. Talley-245 W. Patrick St.-		Address Frederick-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperthensive arteriosclerotic heart disease DUE TO 44 Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) DUE TO lying cause last. (c)							
INTERVAL BETWEEN ONSET AND DEATH 4 years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1954 to Aug. 3 , 1958 that I last saw the deceased alive on Aug. 3 , 1958, and that death occurred at Z.A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Rex H. Martin				ADDRESS (Street, city or town, state) 35 E Church Frederick MD DATE SIGNED 8-4-58			
PHYSICIAN'S NAME (Type) Dr. Rex Martin		35 East Church Street, Frederick, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick- Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Clegg & Son		ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE AUG 6 '58		24b. REGISTRAR'S SIGNATURE Albert	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please retain carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be reigned by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
Page 3 should be detached, use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9052 Items 2,3,4,5,6,7,8-11-5 st

69052

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <i>Frederick</i>		c. LENGTH OF STAY IN lb <i>37 days.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. airy</i>			
d. STREET ADDRESS <i>mt. airy</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Louella</i>	Middle <i>D. Davis</i>	Last <i>DANIS</i>		
4. DATE OF DEATH <i>Aug 3, 1958</i>	Month <i>Aug</i>	Year <i>1958</i>	Hour <i>10 AM</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-16-74</i>		
9. AGE (In years last birthday) <i>83 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 48 HRS Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Museums</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country) <i>Maryland</i></i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Wm Conaway</i>			
14. MOTHER'S MAIDEN NAME <i>Clementine Pen</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Hospital Records.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral hemorrhage</i>					
DUE TO (c) <i>Chronic hypertension</i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
INTERVAL BETWEEN ONSET AND DEATH <i>Jan 1, 1958</i>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>High blood pressure</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>					
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>May 1, 1958</i> , to <i>Aug 3, 1958</i> , that I last saw the deceased alive on <i>Aug 2, 1958</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>212 W. Kendal Street, Baltimore, Md.</i>					
DATE SIGNED <i>8/5/58</i>					
ACTUAL SIGNATURE <i>M. McKendree Boyer</i>					
PHYSICIAN'S NAME (Type) <i>M. McKendree Boyer</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8-8-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>PINE GROVE</i>	22d. LOCATION (City, town, or county) <i>MT. AIRY</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. M. Watz</i>			ADDRESS <i>Linfield, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>AUG 7 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Aut. seal</i>
VS A15 (4) 1SM 9/55					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09653

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	
<i>Frederick MARYLAND</i>		<i>MARYLAND CARROLL</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>RURAL Frederick</i>	<i>5 DAYS</i>	<i>UNION BRIDGE</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Frederick Memorial Hosp.</i>		<i>BROADWAY</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Edward THOMAS Devilbiss</i>			
4. DATE OF DEATH	Month	Day	Year
	<i>Aug</i>	<i>12</i>	<i>1958</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>M</i>	<i>W</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>3/13/1871</i>
9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min
<i>87 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>FARMER - RETIRED - OWNER</i>		<i>MARYLAND</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>MARYLAND</i>		<i>U.S.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>ADAM DEVILBISS</i>		<i>JOSEPHINE LOOKINGBILL</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>NONE</i>	
17. INFORMANT		Address	
<i>O.B. DEVILBISS UNION BRIDGE MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Congestive Heart failure</i>	
4xU=U DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		<i>2 WKS</i>	
(b) DUE TO (c)		<i>Arteriosclerotic Heart disease</i>	
		<i>10 yrs +</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>8/6</i> , 1958, to <i>8/12</i> , 1958, that I last saw the deceased alive on <i>8/12</i> , 1958, and that death occurred at 10 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>Henry V. Chase</i>		DATE SIGNED <i>8/13/58</i>	
PHYSICIAN'S NAME (Type)		<i>4 E. Church St</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>BVR 7A1</i>		<i>AUG 15-58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)	
<i>WITHERAIN CEM. UNIONTOWN</i>		<i>M.D.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<i>DD Fletcher-Lous Union Bridge Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	
ADDRESS		DATE <i>AUG 18 '58</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



X

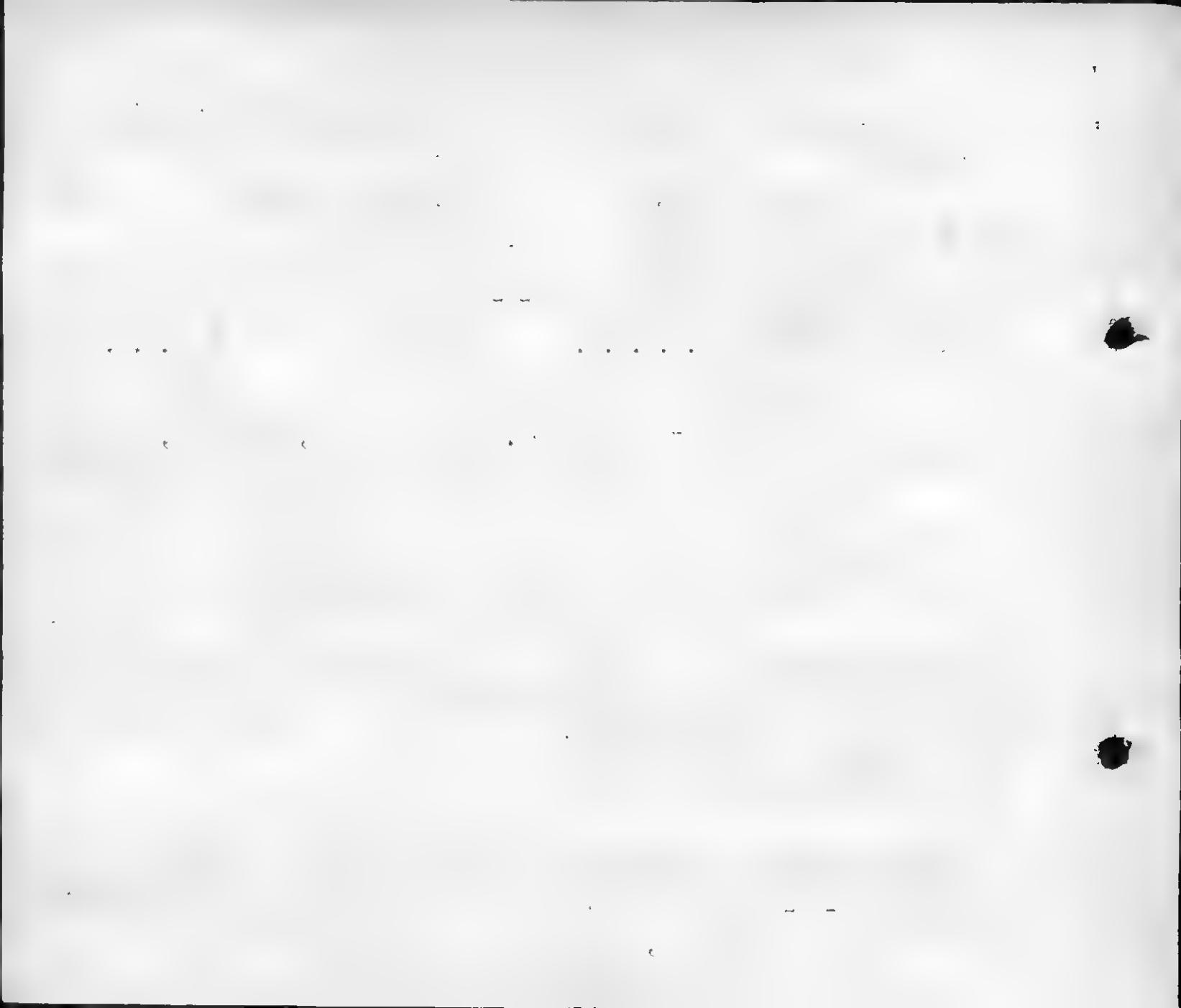
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached or use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **09054**

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 502 Brunswick Street				d. STREET ADDRESS 502 Brunswick Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James Lilburn		First	Middle	Last	4. DATE OF DEATH Dixon
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 4-8-1883	9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor		10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Dixon		14. MOTHER'S MAIDEN NAME Annie Bowen		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 705-09-7702		17. INFORMANT Mrs. Margaret Dixon, Brunswick, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Angina pectoris					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 15 S. Maryland Ave. Brunswick	(County) 8-16-58 (State)
21. I certify that I attended the deceased from July 16, 1958 , to Aug. 15, 1958 , that I last saw the deceased alive on Aug. 15, 1958 , and that death occurred at 10:04 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE 		DATE SIGNED			
PHYSICIAN'S NAME (Type) C. T. Byron Kao, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-19-1958	22c. NAME OF CEMETERY OR CREMATORIUM Lutheran	22d. LOCATION (City, town, or county) Lovettsville (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Brunswick, Maryland	24a. REC'D BY REGISTRAR AUG 26 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09055

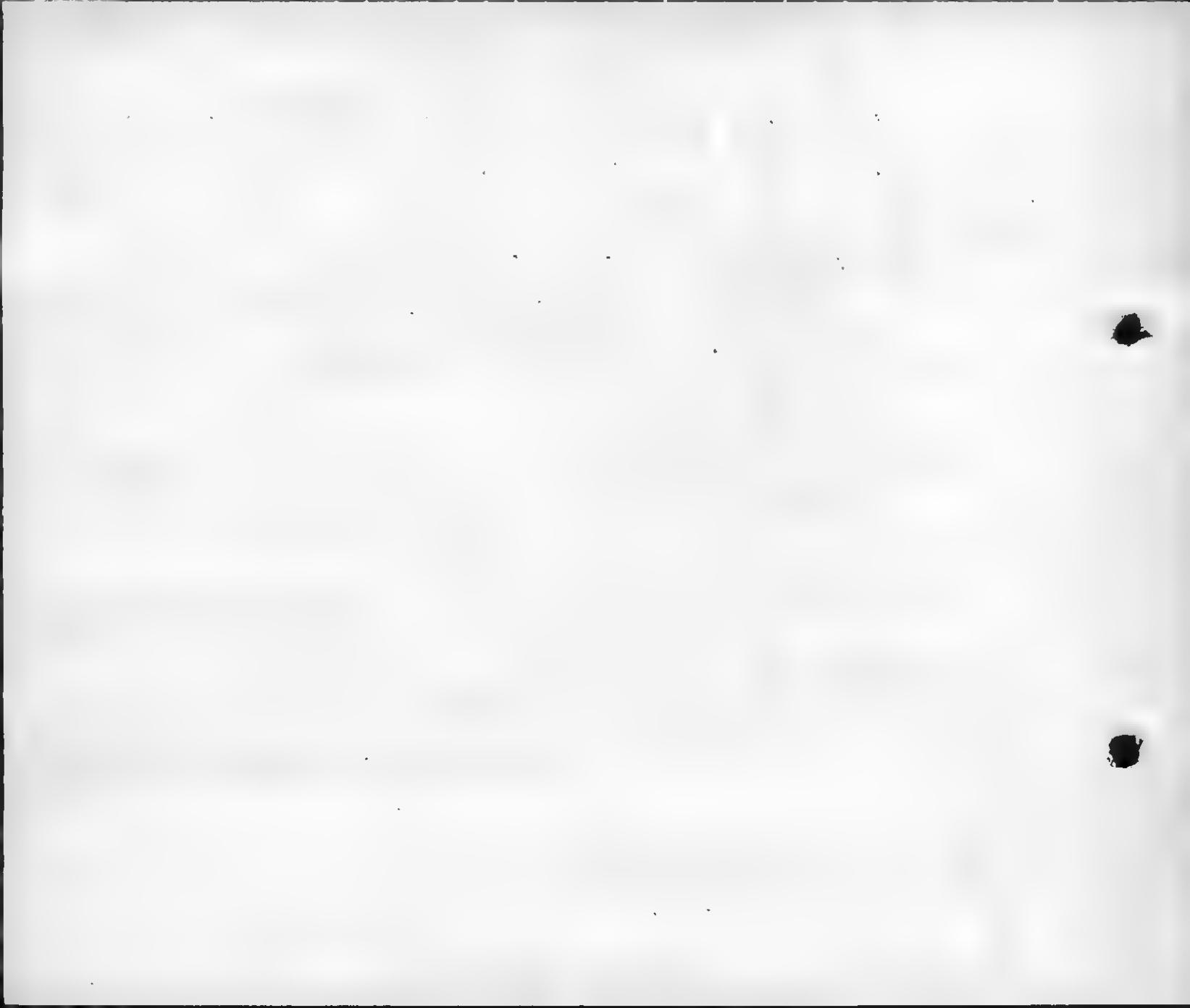
9080

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A doctor's certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODSBORO		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODSBORO				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ROBERT JEFFERSON DONSIFE		First	Middle	Last	4. DATE OF DEATH August 11 1958	Month	Day	Year
5. SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAR 26 1878	9 AGE (in years last birthday) 80 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLACKSMITH		10b. KIND OF BUSINESS OR INDUSTRY CVN SHOP		11. BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME OTHO DONSIFE		14. MOTHER'S MAIDEN NAME MARY GEESEY						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 218-34-3965		17. INFORMANT CELESTE DONSIFE		Address WOODSBORO MD		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Disease - 7 strokes		DUE TO 120.1		INTERVAL BETWEEN ONSET AND DEATH see below				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - earlier 10 strokes		DUE TO 120.1						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Aug 5 1958 to August 11 1958 , that I last saw the deceased alive on Aug 5 1958 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state), Midville, Md. Aug 11 1958 DATE SIGNED 11/1/1958						
ACTUAL SIGNATURE E. A. DETTBARN		M.D. WALKERSVILLE MD						
PHYSICIAN'S NAME (Type) E. A. DETTBARN								
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 14 1958		22c. NAME OF CEMETERY OR CREMATORIAL MT HOPE		22d. LOCATION (City, town, or county) (State) WOODSBORO MD		
23. FUNERAL DIRECTOR'S SIGNATURE Powell & Hartley Woodsboro, Md		ADDRESS POWELL & HARTLEY WOODSBORO, MD		24a. REC'D BY REGISTRAR JUL 13 1958		24b. REGISTRAR'S SIGNATURE ARTHUR S. KRAUS		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item # 9054 62-5-2-58 et
CERTIFICATE OF DEATH

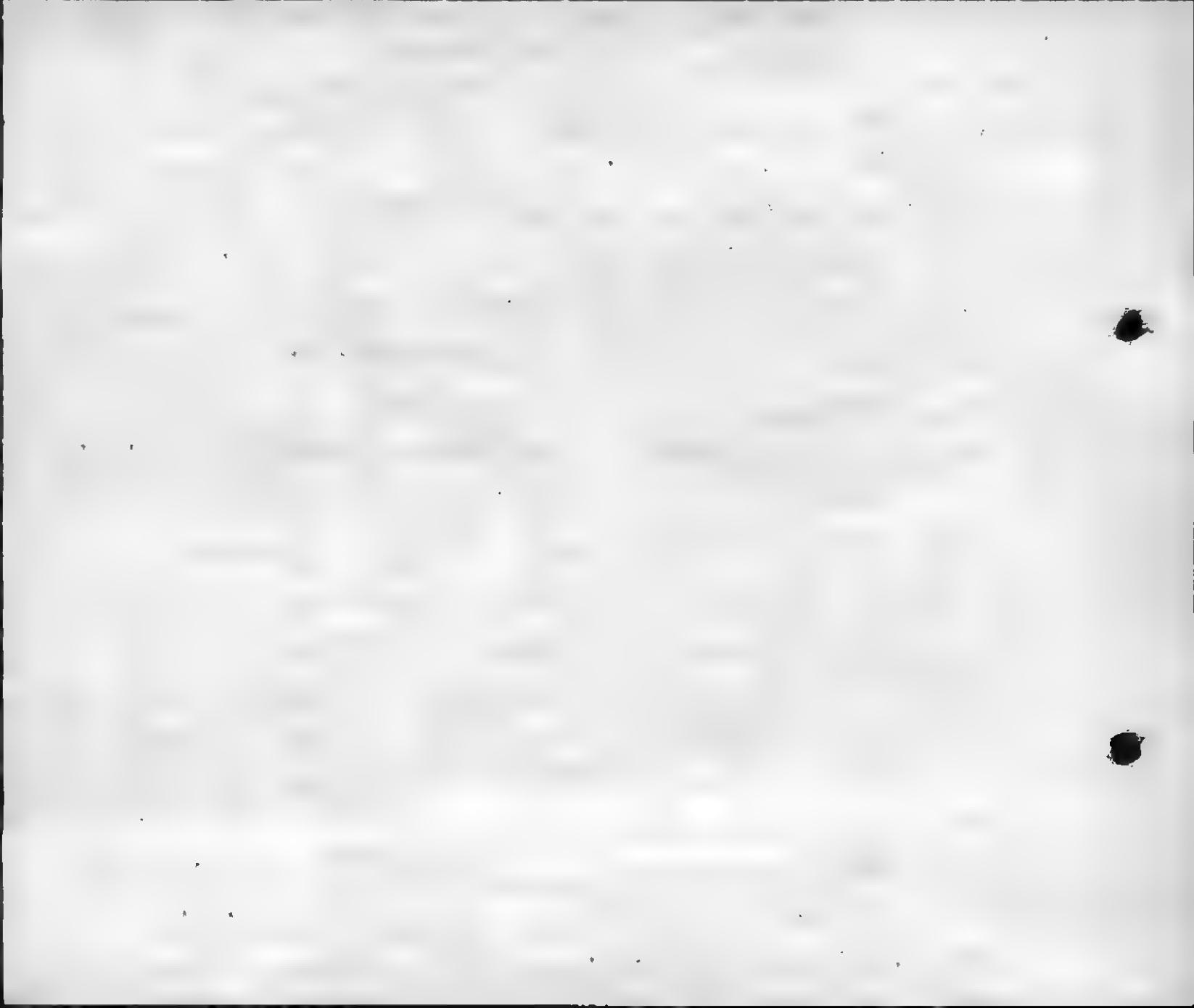
Reg. Dist. No.

89056

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 121 Ice Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) Harry Gilmore Dorsey		4. DATE OF DEATH Aug. 21 1958	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown	8. DATE OF BIRTH Approx. 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmers Helper		10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) Montgomery Co. Md.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Pearl Dorsey Address 121 Ice Street Fred. Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-1-1957 to 8-21-1958 , that I last saw the deceased alive on 8-21-58 , and that death occurred at 2:45 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Rex Martin ADDRESS (Street, city or town, state) 355 Church Industrial Rd DATE SIGNED 8-22-58			
PHYSICIAN'S NAME (Type) Rex Martin		Church Street Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-25-58	22c. NAME OF CEMETERY OR CREMATORIUM Friendship
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III Frederick, Md.		24a. REC'D BY REGISTRAR DATE AUG 29 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A **b**'s certificate has been signed by the attending physician and **c** page 3 should be detached and given to the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9055 CERTIFICATE OF DEATH

Reg. Dist. No.

09657

1. PLACE OF DEATH a. COUNTY Frederick		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		b. COUNTY Frederick	
c. LENGTH OF STAY IN lb Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Doubts	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First ABRAM	Middle BRANDT	Last EARHART	4. DATE OF DEATH August 26, 1958
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH January 9, 1888	9. AGE (In years lost birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe-Salesman		10b. KIND OF BUSINESS OR INDUSTRY Shoes	11. BIRTHPLACE (State or foreign country) Penna.	12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no. or unknown) No	16. SOCIAL SECURITY NO 220-18-0698	17. INFORMANT Mrs. Minnie C. Earhart—Same as Item #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Cancer of stomach with metastases, 8 mo</i>
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PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 17, 1958, to Aug 26, 1958, that I last saw the deceased alive on Aug 26, 1958, and that death occurred at 2:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE
Rex R. Martin
PHYSICIAN'S NAME (Type)
Dr. Rex R. Martin

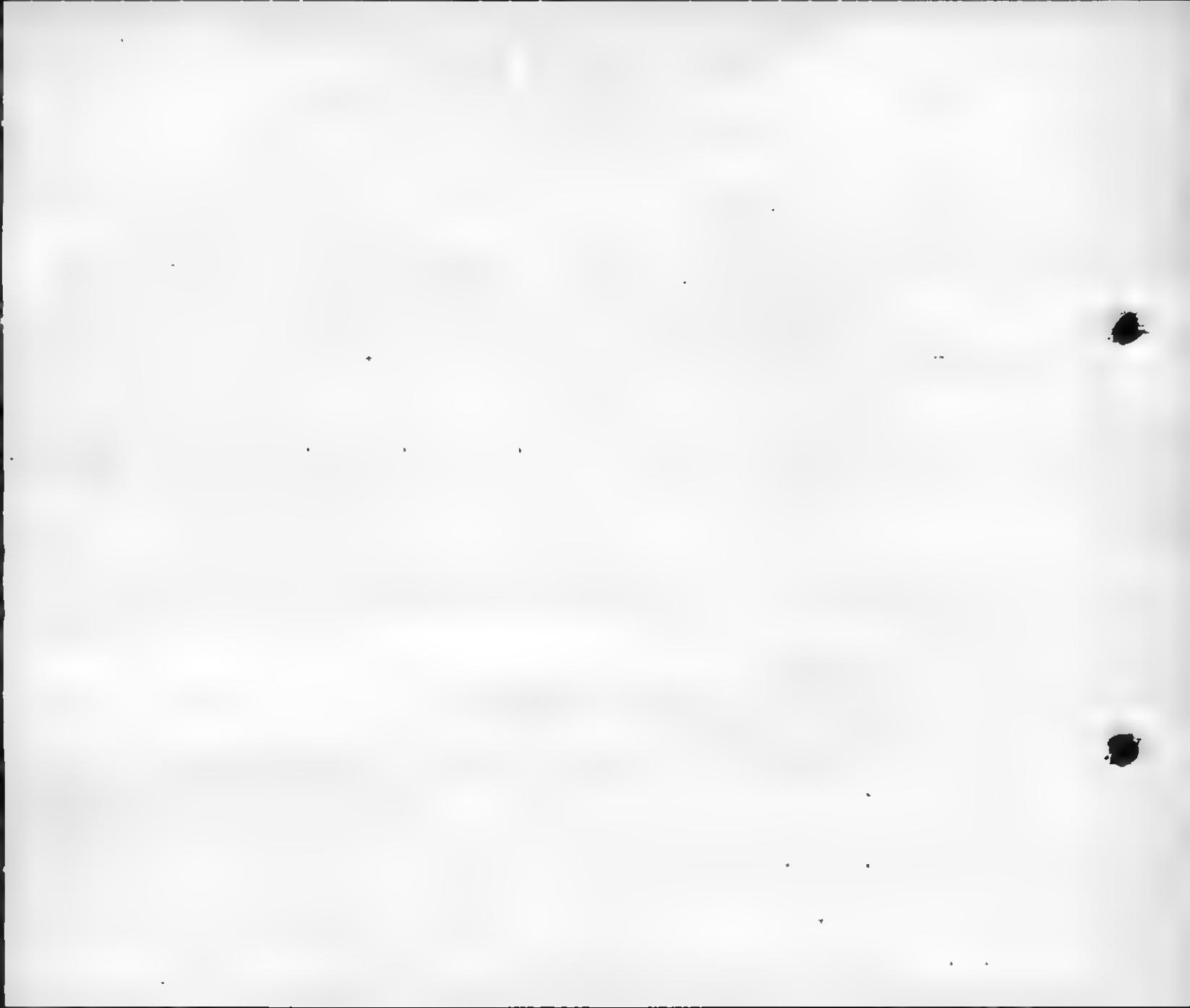
ADDRESS (Street, city or town, state)

East Church Street

DATE SIGNED

8/27/58

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 29, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 2 '58
		24b. REGISTRAR'S SIGNATURE <i>Albert S. Trahan</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9056

CERTIFICATE OF DEATH

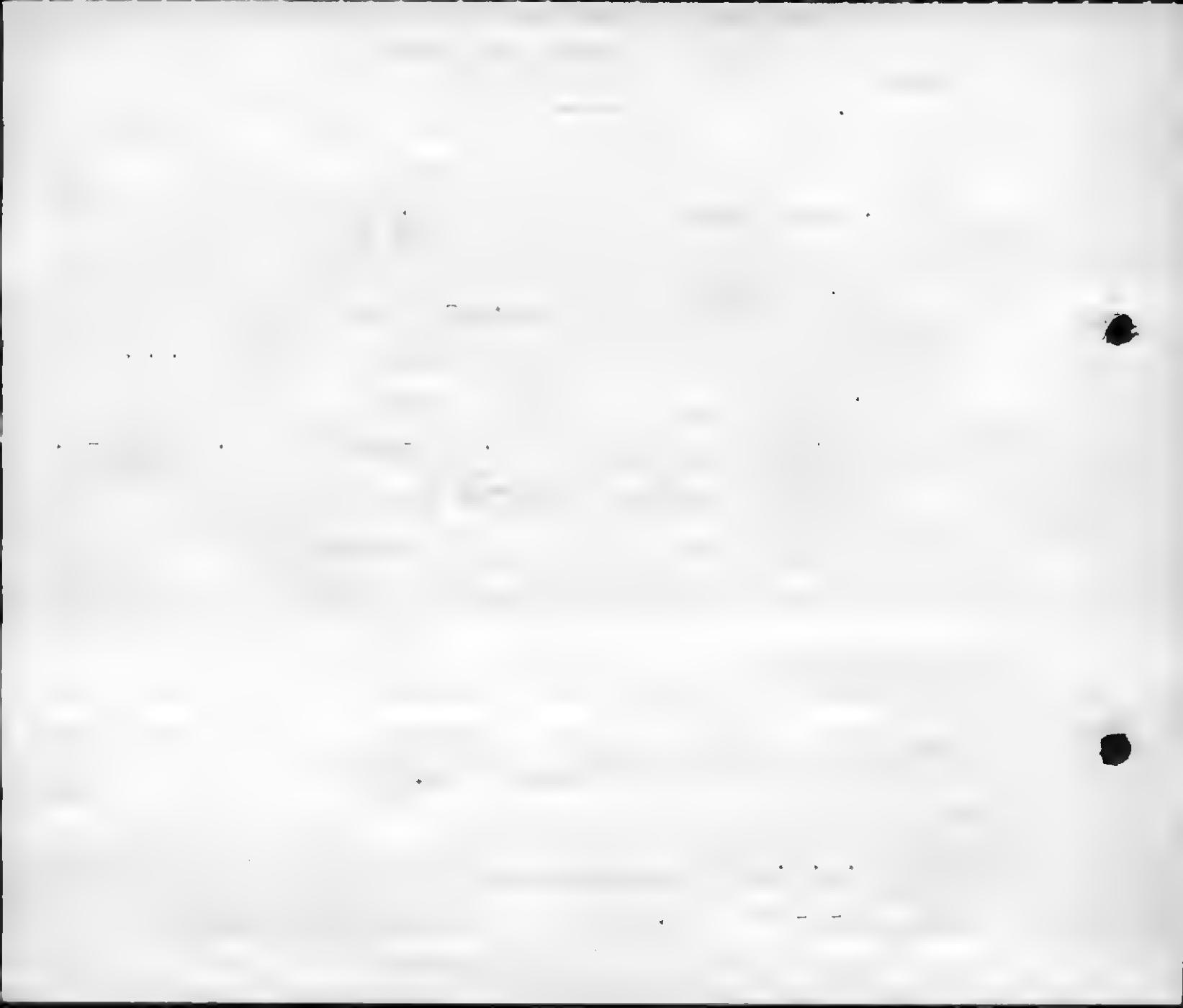
Reg. Dist. No.

69058

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 214 W. Patrick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Samuel	Middle Heffner	Last Ebert
4. DATE OF DEATH	Month August	Day 27	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Divorced	8. DATE OF BIRTH Jan. 18-1891
9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur	10b. KIND OF BUSINESS OR INDUSTRY Private driving	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward C. Ebert	14. MOTHER'S MAIDEN NAME Annie Neff		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. None	17. INFORMANT John E. Ebert-West Patrick St.-Frederick-Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last. b. DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 28, 1958 , to Aug. 29, 1958 , that I last saw the deceased alive on Aug. 28, 1958 , and that death occurred at 5 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North Market Street - Frederick, Maryland			
ACTUAL SIGNATURE B. Thomas	DATE SIGNED August 29, 1958		
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-30-1958	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son	ADDRESS Frederick-Maryland	24a. REC'D BY REGISTRAR SEP 2 '58	24b. REGISTRAR'S SIGNATURE Orville S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9057

CERTIFICATE OF DEATH

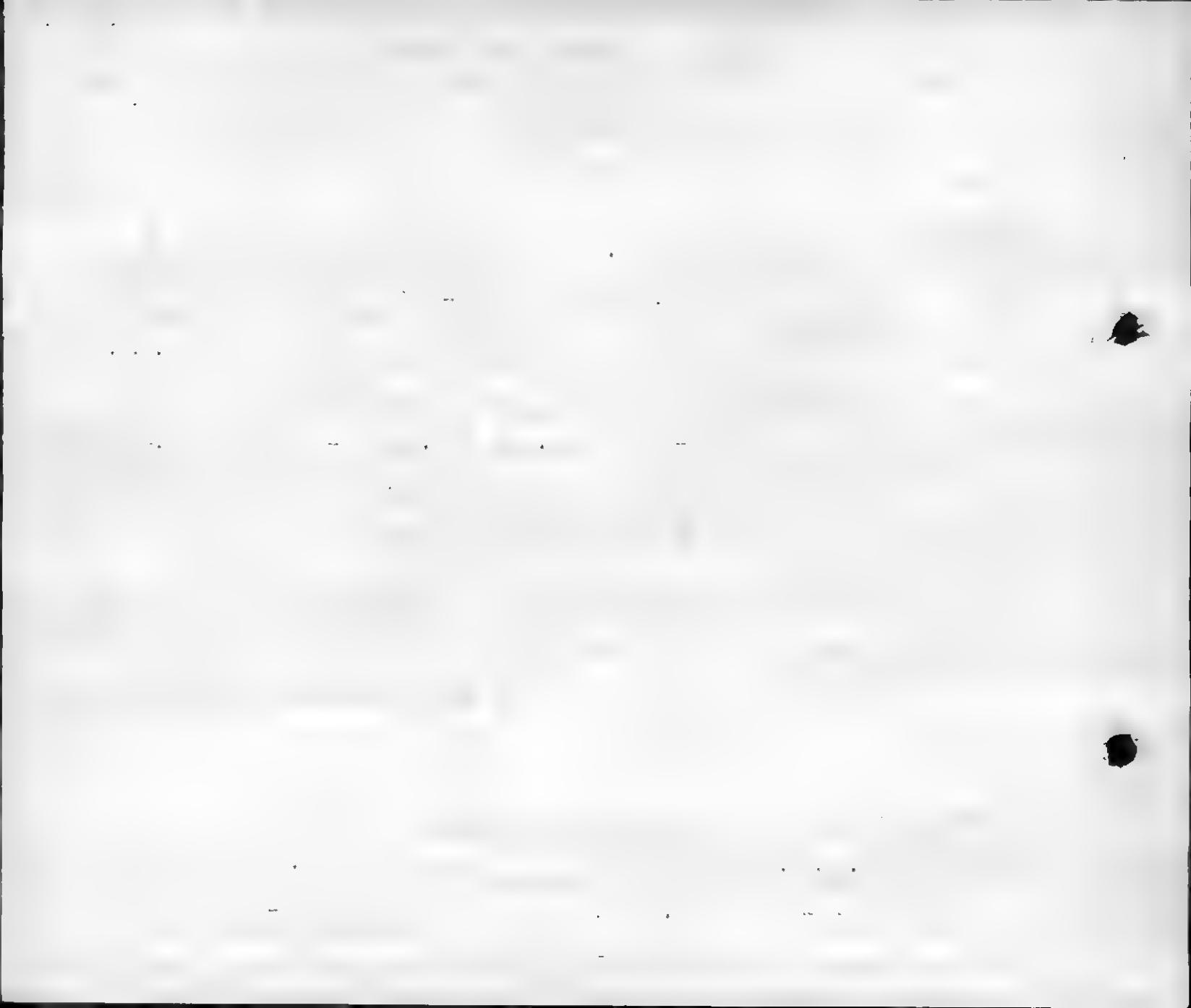
Reg. Dist. No.

69059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A. This certificate has been signed by the attending physician and completely filled in by the funeral director.
 page 3 should be detached and use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE	
Frederick MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Frederick Lifetime		Frederick	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
200 Thomas Avenue		200 Thomas Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Samuel	Middle L.	Last Eppley
4. DATE OF DEATH	Month August	Day 21	Year 1958
5. SEX	6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH
Male	White	Widowed	April 1-1883
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	
75 yrs.	Months	Days	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Supervisor Packing Room	Hosiery Mill	Maryland	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
John Francis Eppley	Mary Lease Eppley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	214-10-3417	Mrs. Samuel L. Eppley-200 Thomas Ave.-Frederick	Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
DUE TO <i>Classic Myocarditis</i>			
INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b) <i>Arterial Detoxis</i>			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. F. Kline</i>		ADDRESS (Street, city or town, state) M.D. Frederick Md. 21 North Market St., Frederick, Maryland	
DATE SIGNED Aug 25 1958			
PHYSICIAN'S NAME (Type)		Dr. H. F. Kline	
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 8-25-1958	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Cline & Son</i>		24a. REC'D BY REGISTRAR DATE AUG 25 1958	
ADDRESS Frederick-Maryland		24b. REGISTRAR'S SIGNATURE <i>Caroline S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09660

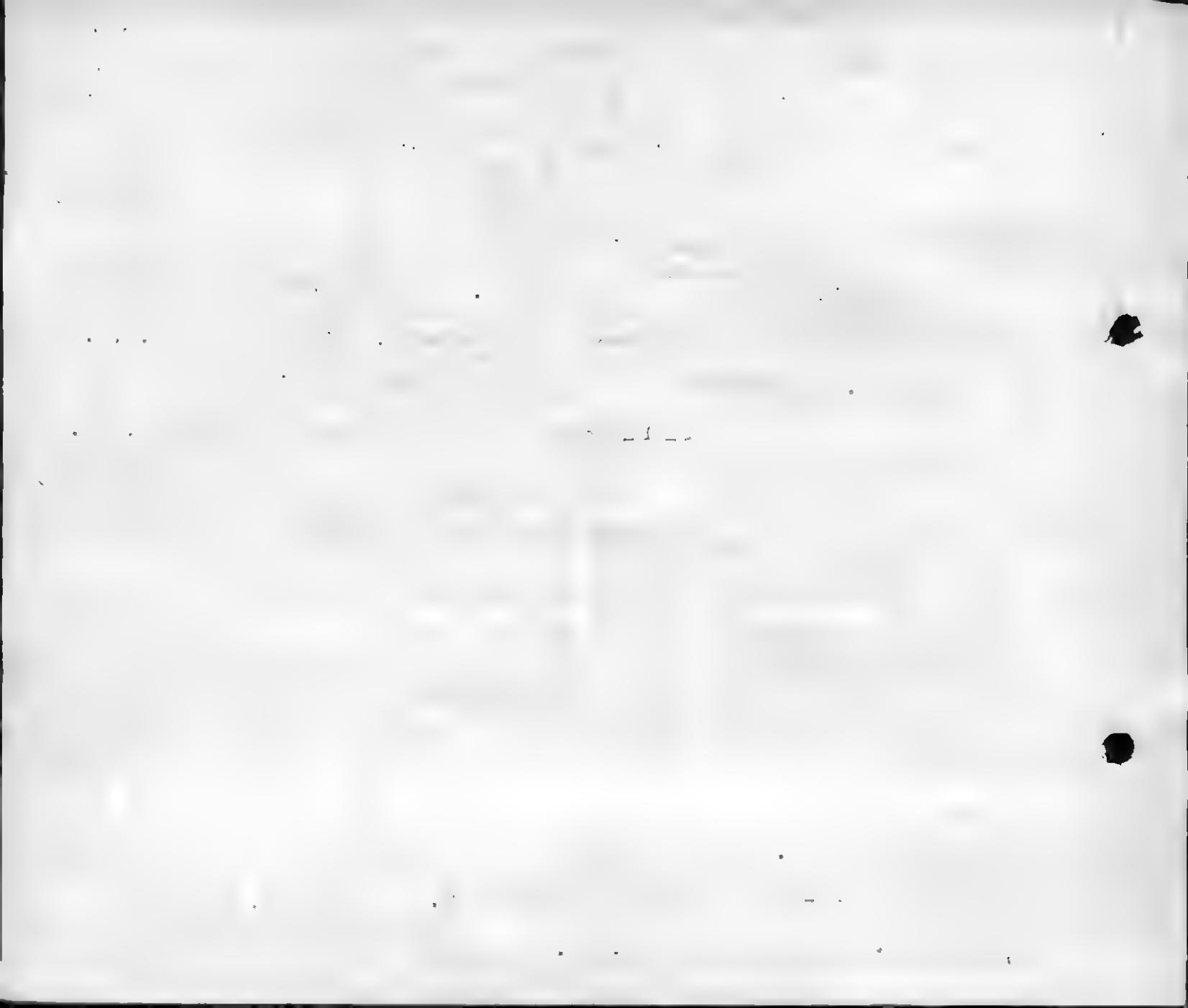
9081

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN b. Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
3. NAME OF DECEASED (Type or print) Harry Glenn Finneyfrock		First Harry	Middle Glenn
		Lost	4. DATE OF DEATH Month August Day 29 Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12 1890
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years (to birthday) yrs.) 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fruit dealer		10b. KIND OF BUSINESS OR INDUSTRY Own business	11. BIRTHPLACE (State or foreign country) Thurmont, Maryland
13. FATHER'S NAME Harvey J. Finneyfrock		14. MOTHER'S MAIDEN NAME Georgiann Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 214-34-1092	17. INFORMANT Kenneth Finneyfrock
		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 421.4		INTERVAL BETWEEN ONSET AND DEATH Sudden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO — (c)		Coronary Occlusion C. br. valvular heart disease 4-5 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 0 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 15 , 19 58 to Aug. 29 , 19 58 , that I last saw the deceased alive on Aug. 15 , 19 58 , and that death occurred at 10 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Thurmont - Md DATE SIGNED 8-30-58	
ACTUAL SIGNATURE James K. Gray		M.D.	
PHYSICIAN'S NAME (Type) James K. Gray			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-1-58	22c. NAME OF CEMETERY OR CREMATORIUM United Brethren Cem.
22d. LOCATION (City, town, or county) Thurmont, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	24a. REC'D BY REGISTRAR DATE SEP 2 '58
		24b. REGISTRAR'S SIGNATURE C. James E. Krause	



09661

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be used for your files.

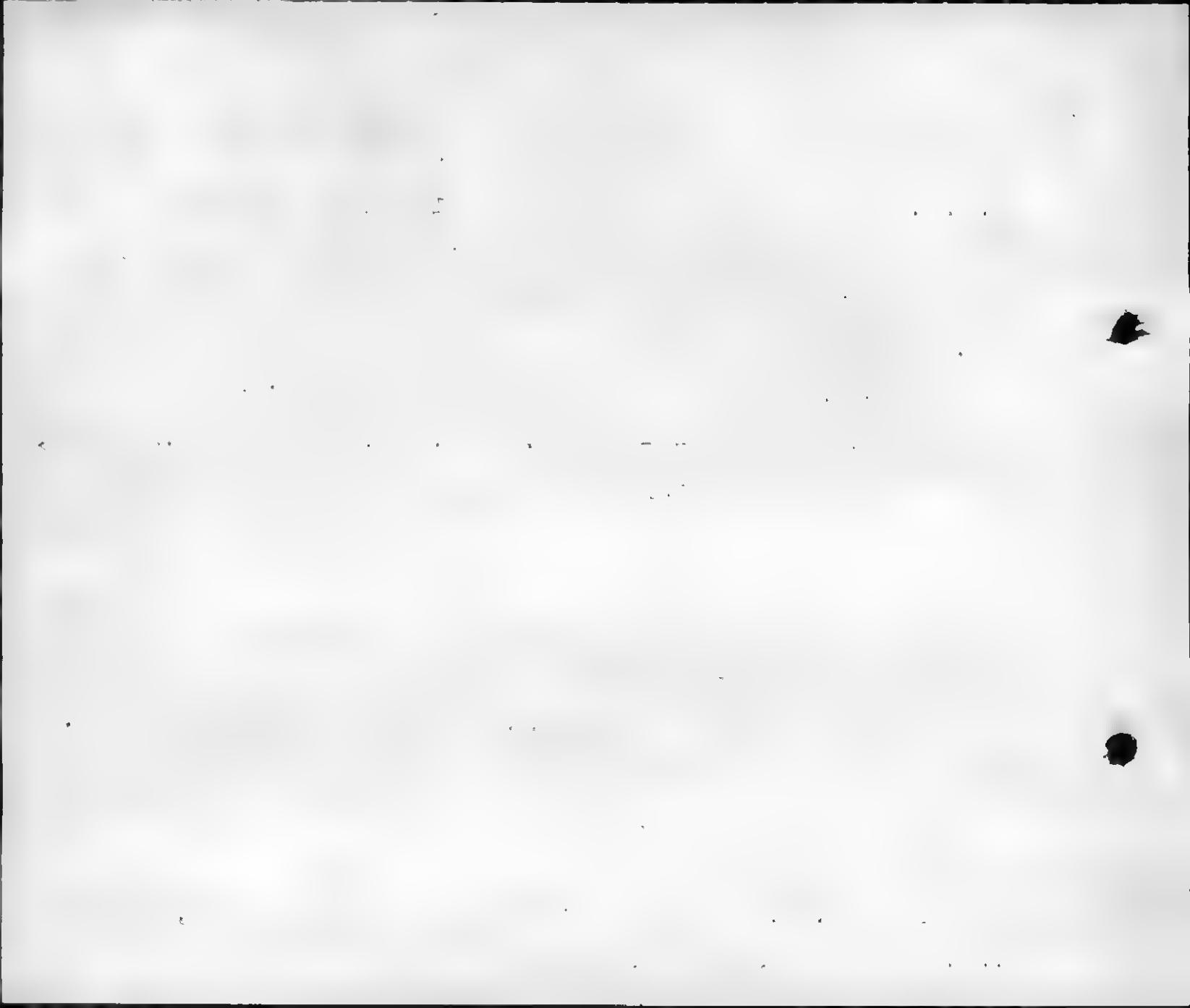
TO FUNERAL DIRECTOR: Item 3 should be used as a burial transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9058 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Frederick Memorial Hospital		e. 5 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLIAN		First FLORENCE	Middle FOGIE
4. DATE OF DEATH August 8, 1958		Month August	Day 8 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 4, 1933
8. AGED (In years last birthday) 25		9. IF UNDER 1 YEAR Months 0 Days 0	10. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reg. Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Claude William Fogle		14. MOTHER'S MAIDEN NAME Nora Maude Hurst Holt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-28-3529	17. INFORMANT Address Mrs. Nora M. Holt, 500 Fairview Ave., Frederick, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X		DUE TO Gun Shot Wound of Skull	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. b.		INTERVAL BETWEEN ONSET AND DEATH 1½ Hours	
DUE TO c.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Self-Inflicted	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Off U.S. #15
20f. (City or town) Near Frederick,	(County) Md.	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>B.C. Thomas</i>	DATE SIGNED 8/9/58		
EXAMINER'S NAME (Type) B.C. Thomas	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 11, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Union Chapel Cemetery	22d. LOCATION (City, town, or county) Frederick County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland	ADDRESS	24a. REC'D BY REGISTRAR Arthur S. Evans	24b. REGISTRAR'S SIGNATURE Arthur S. Evans
VS. A15ME(S) 5M 9/55		DATE AUG 13 '58	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9082

69062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN lb HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE 240		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALKERSVILLE	
f. STREET ADDRESS /		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Franklin Fogle		First	Middle
		Last	4. DATE OF DEATH August 8
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH July 16, 1919
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO DEALER		10b. KIND OF BUSINESS OR INDUSTRY USED CARS	9. AGE (in years last birthday) 39 yrs.
10c. BIRTHPLACE (State or foreign country) MARYLAND		11. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
13. FATHER'S NAME CHARLES H. FOGLE		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UN KNOWN	17. INFORMANT BESSIE J FOGLE
		Address WALKERSVILLE MD RURAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)		Gun shot of Brain	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE B. O. Thomas		DATE SIGNED August 8, 1958	
EXAMINER'S NAME (Type) B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 10 - 1958	
22c. NAME OF CEMETERY OR CREMATORIAL ROCKY HILL		22d. LOCATION (City, town, or county) (State) WOODSBORO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Powell & Hartzler Woodsboro, Md		24a. REC'D BY REGISTRAR Arthur J. Krause	
		24b. REGISTRAR'S SIGNATURE AUG 12 1958	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files.

TO FUNERAL DIRECTOR: Item 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9059 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 Years				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
3. NAME OF DECEASED (Type or print) ARTHUR		First PERCY	Middle FORSYTH			
4. DATE OF DEATH August 22, 1958		Last 82	Month Year Day			
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 13, 1875			
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Attorney at Law	11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Arthur P. Forsyth						
14. MOTHER'S MAIDEN NAME Amanda Clark						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None				
17. INFORMANT Mrs. James Grove (Same as item #2)		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured Skull						
INTERVAL BETWEEN ONSET AND DEATH 8 Hours						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY REFORMED?						
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell from a wagon load of Hay				
20c. TIME OF INJURY Hour 3:15 p.m. Month, Day, Year Aug. 22 1958		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Cooksville-Howard-Maryland	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-23-58		
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-26-58	22c. NAME OF CEMETERY OR CREMATORIUM Oak Grove Cemetery	22d. LOCATION (City, town, or county) Glenwood, Howard County, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hector J. Hight, Chillum, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR Citation S. Thomas	24b. REGISTRAR'S SIGNATURE <i>Citation S. Thomas</i>	DATE AUG 27 '58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

69064

9083

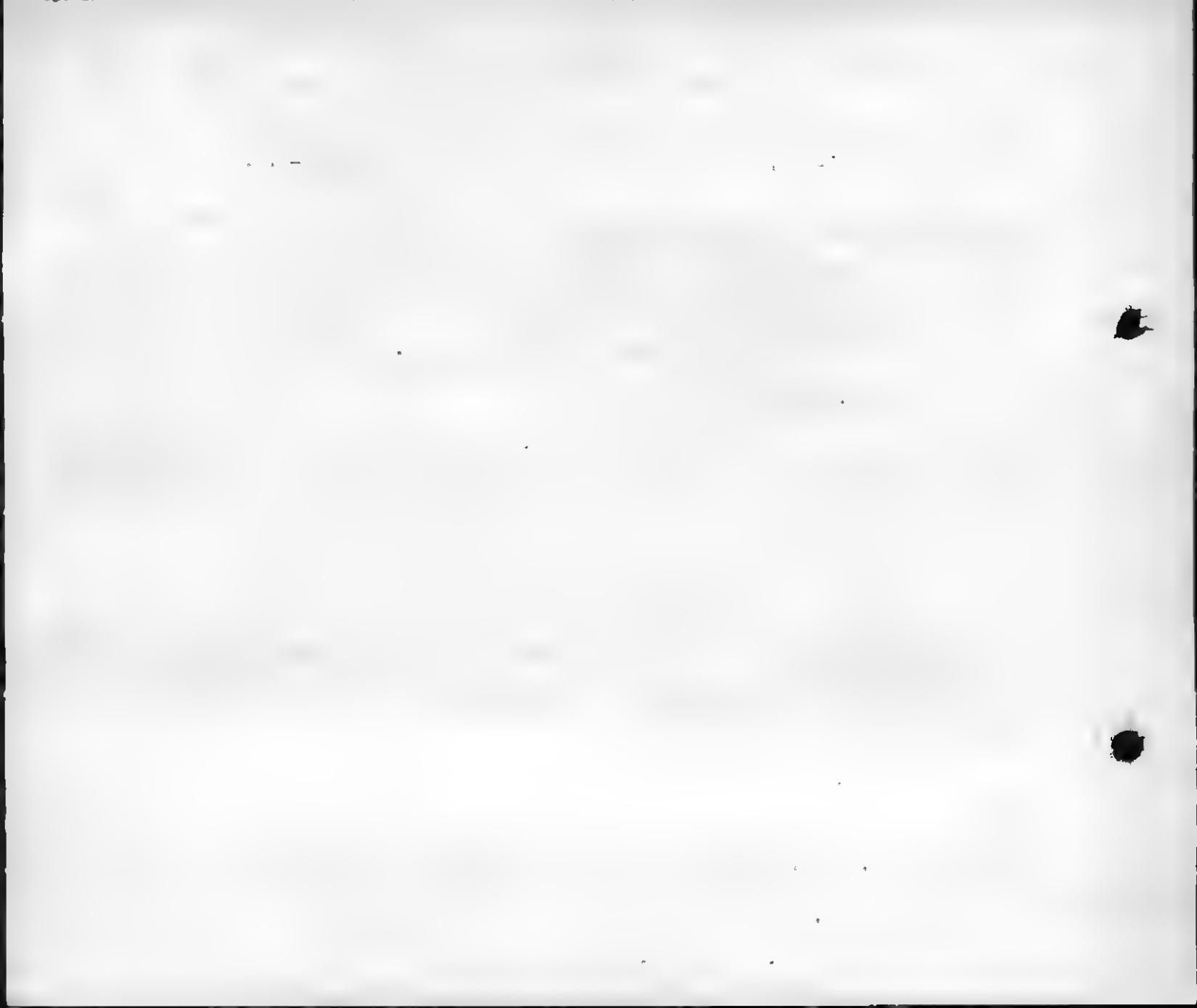
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural-R.D.#1		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville-Rural-R.D.#1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near New Market		d. STREET ADDRESS Near New Market		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Also Known As: John David Gorman)		Lost GARMAN		4. DATE OF DEATH August 21, 1958	Month Doy Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 27, 1905	9. AGE (In years and birthday) 52 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Tenant		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME John D. Garman		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 217-30-5467		17. INFORMANT Mrs. Gertrude Garman—Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION				INTERVAL BETWEEN ONSET AND DEATH 2 HOUR	
400.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1958 to August 21, 1958 , that I last saw the deceased alive on August 17, 1958 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED B. O. Thomas 8/22/58	
ACTUAL SIGNATURE B. O. Thomas		M. D. Professional Building			
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas		Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 24, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Rocky Springs Cemetery	
22d. LOCATION (City, town, or county) Frederick County, Maryland				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REG'D BY REGISTRAR AUG 25 1958	
				24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: At this certificate has been signed by the attending physician and completely filled in by the funeral director.
 page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

69465

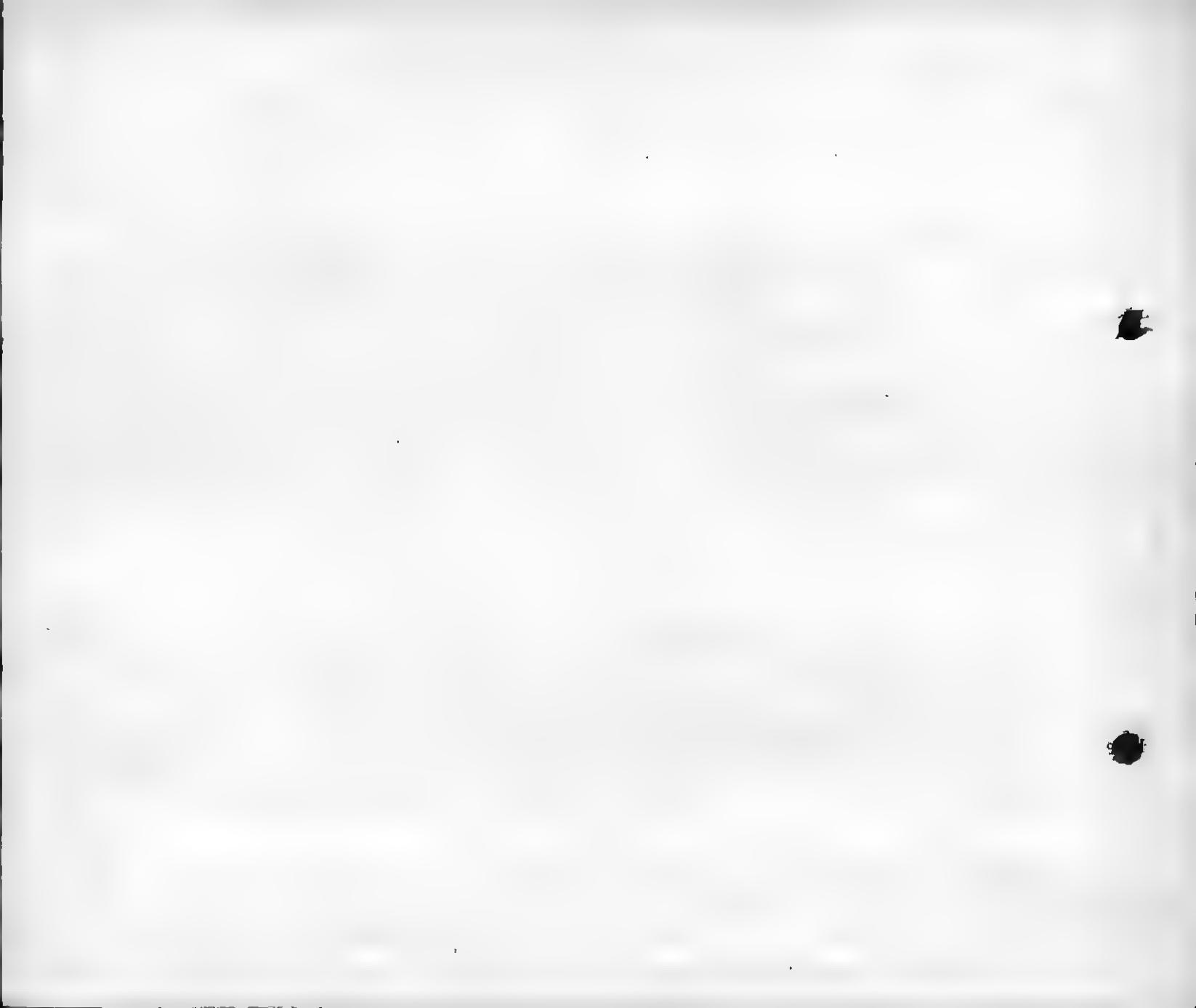
9084

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE		MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALKERSVILLE		c. LENGTH OF STAY IN lb 2 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS ROUTE 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
BERTIE				L. GRABILL	AUG. 25				
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 21-1887		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Year Hours Min.	
F	W								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME BRADLEY RIPPEON		14. MOTHER'S MAIDEN NAME MARTHA FRITZ							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT GLADYS RAMSBURG		Address MD WALKERSVILLE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pulmonary disease				INTERVAL BETWEEN ONSET AND DEATH 1 day			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first		(b) Cerebral hemorrhage				3 week			
(c) Intracardiac cardiac vascular disease						- never - - age -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) H. 10 Rd	(County)	(State)			
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> to <u>Aug 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 25</u> , 19 <u>58</u> , and that death occurred at <u>H. 10 Rd</u> , from the causes and on the date stated above.				ADDRESS (Street, city, or town, state)		DATE SIGNED Aug 25, 1958			
ACTUAL SIGNATURE <u>E. A. DETTBARN</u>		M.D.							
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 28-1958		22c. NAME OF CEMETERY OR CREMATORIAL FAIRMOUNT		22d. LOCATION (City, town, or county) LIBERTYTON			
		ADDRESS Union Bridge, Md.				(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE D. D. Glithero (Union Bridge, Md.)				24a. REC'D BY REGISTRAR AUG 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

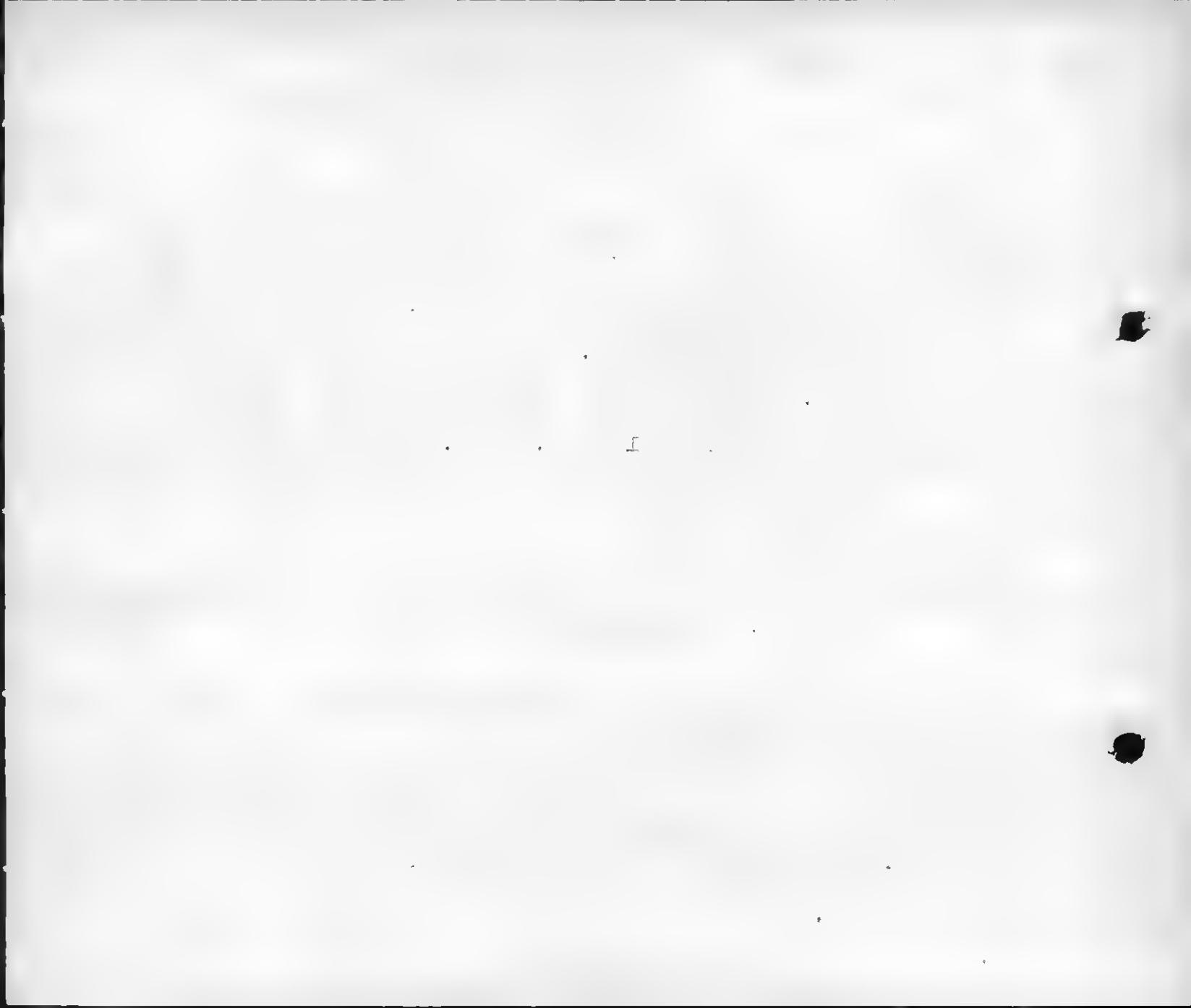
69666

9060

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 328 East Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First LLOYD	Middle ALPHIUS	Last GROSSNICKLE	4. DATE OF DEATH August 24,	Month Day Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> November 25, 1893	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buffer		10b. KIND OF BUSINESS OR INDUSTRY Aluminum Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leonard A. Grossnickle				14. MOTHER'S MAIDEN NAME Mary Elizabeth Renner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO No		17. INFORMANT 219-14-8207		Address Mr. Mark H. Baker—Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X		Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 2½ days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterio sclerotic heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4PM on 8/24, 1958, to 10:15 PM on 8/24, 1958, that I last saw the deceased alive on 8/24, 1958, and that death occurred at 10:15 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Shopping Center DATE SIGNED ACTUAL SIGNATURE Ralph L. Michels 8/26/58							
PHYSICIAN'S NAME (Type) Dr. Ralph L. Michels				Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 29, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Middletown, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 27 '58		24b. REGISTRAR'S SIGNATURE Arthur G. Haas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9061 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09067

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick -Rural-R.D.#2		d. STREET ADDRESS Ball Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print)		First GEORGE	Middle WASHINGTON	Last HALLER, JR.	4. DATE OF DEATH Month August Day 21, Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 30, 1899	9. AGE (In years at birthday) 59 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Haller, Sr.				14. MOTHER'S MAIDEN NAME Nettie Hamilton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-0746		17. INFORMANT Mr. George W. Haller Jr., 220 South Carroll St., Frederick, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH 400.1 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIOVASCULAR DISEASE DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Frederick (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B. O. Thomas				DATE SIGNED 8/28/58			
EXAMINER'S NAME (Type) Dr. B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 25, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 25 '58	24b. REGISTRAR'S SIGNATURE Arnold L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after executing the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files.

TO FUNERAL DIRECTOR: File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

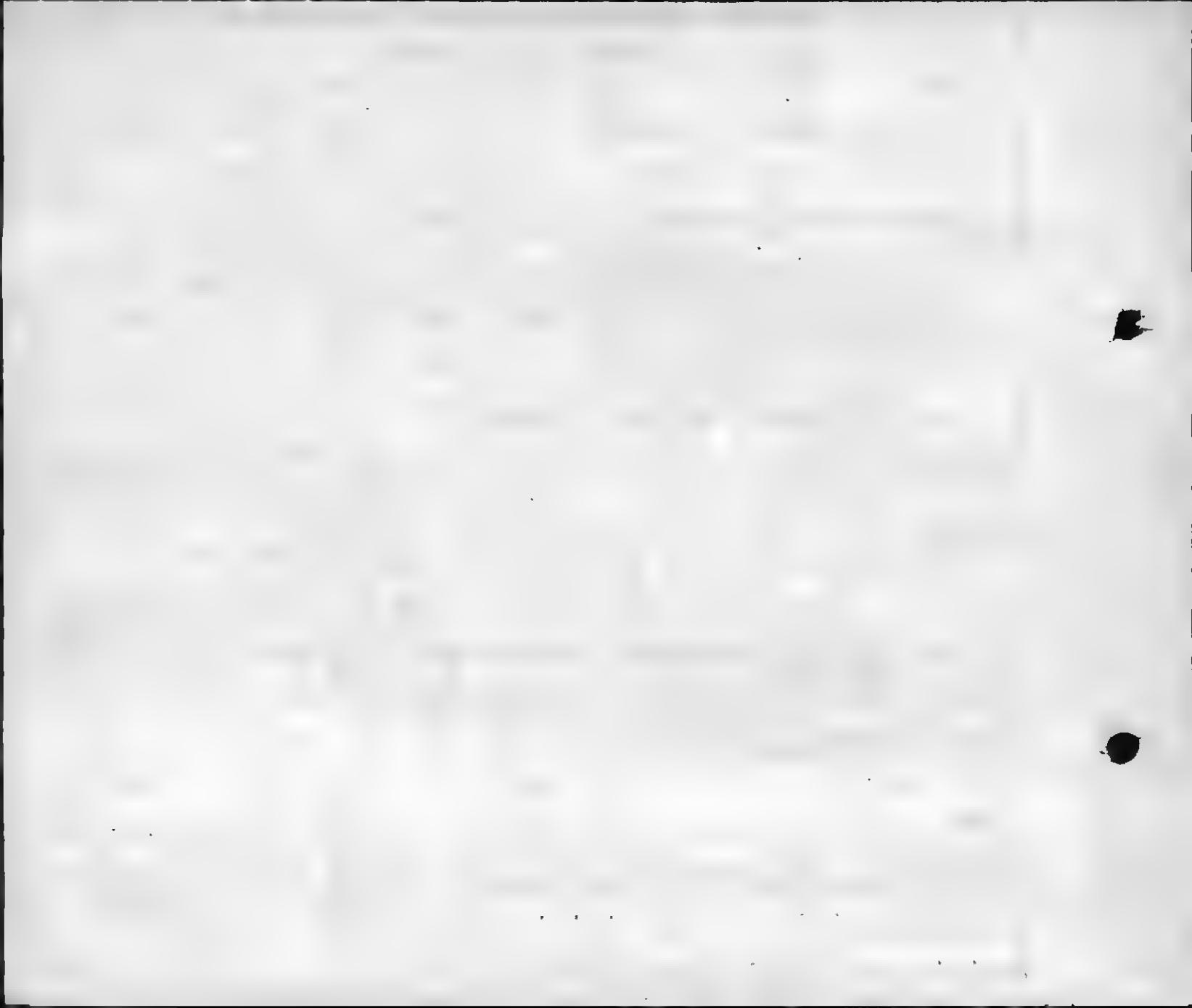
Reg. Dist. No.

09068

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)	
Frederick		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Mt. Airy		c. LENGTH OF STAY IN lb 4 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hume - Glisan Mill Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Charles	Middle Augustus
		Last Harris	4. DATE OF DEATH August 23 1958
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH December 5, 1873	
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former		10b. KIND OF BUSINESS OR INDUSTRY Farm	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Richard Harris		14. MOTHER'S MAIDEN NAME Emily Frazier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Mary Harris		Address Samp	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		Acute coronary thrombosis 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1958, to August 1958, that I last saw the deceased alive on Aug. 7 1958, and that death occurred at 8 A. M, from the causes and on the date stated above. ACTUAL SIGNATURE W. B. Caldwell M.D. ADDRESS (Street, city or town, state) Mount Airy DATE SIGNED Aug. 23, 1958			
PHYSICIAN'S NAME (Type)		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-27-58	
22c. NAME OF CEMETERY OR CREMATORIUM Della A. M. E. Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
		24a. REC'D BY REGISTRAR DATE AUG 25 '58	
		24b. REGISTRAR'S SIGNATURE S. Traas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9086

CERTIFICATE OF DEATH

Reg. Dist. No.

09069

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Edna	Middle B	Last Hoffman	4. DATE OF DEATH	Month Aug	Day 9	Year 1958
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5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-16-1886	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRY CLEANING BUSINESS	10b. KIND OF BUSINESS OR INDUSTRY DRY CLEANING	11. BIRTHPLACE (State or foreign country) GREENVILLE, PENNA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME LORENZO	BIMPUS	14. MOTHER'S MAIDEN NAME ALICE BIMPUS
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT MRS. M. D. MONTAGUE	Address 7909 ORCHID ST, N. W. - WASH. D. C.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial infarction 5 minutes		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary Sclerosis 5 years		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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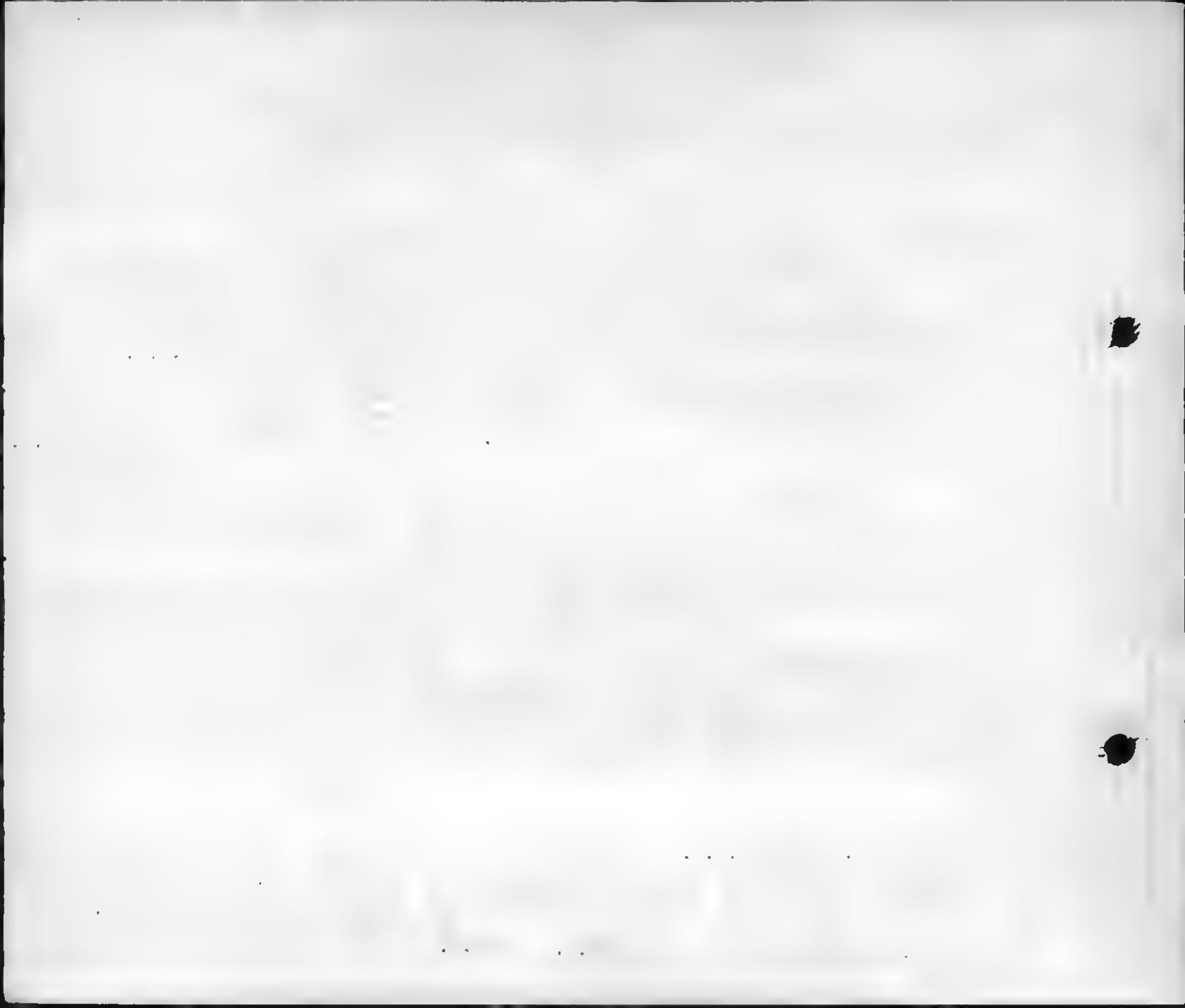
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/4/1958 to 8/9/1958 that I last saw the deceased alive on 8/4/1958, and that death occurred at 12:50 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE S. A. Schoolman, M.D.	22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/13/1958	22c. NAME OF CEMETERY OR CREMATORIUM FORT LINCOLN CEMETERY	22d. LOCATION (City, town, or county) PRINCE GEORGES COUNTY, MD. (State)
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23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSUNG COMPANY-1300 N. ST, N. W. WASH. D. C.	ADDRESS	24a. REC'D BY REGISTRAR AUG 12 1958	24b. REGISTRAR'S SIGNATURE Arthur J. Kraus
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached or use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
9077 CERTIFICATE OF DEATH

Reg. Dist. No. 09070

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 43 East "B"			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick 34		
d. STREET ADDRESS 43 East "B"			d. STREET ADDRESS 43 East "B"		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Nora M. Houser		First	Middle	Last	4. DATE OF DEATH 8-18-1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-1883	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frank Moore			14. MOTHER'S MAIDEN NAME Ella Myers		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> or Unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Ernest M. Houser, Charlestown, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
INTERVAL BETWEEN ONSET AND DEATH 10 yrs.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-14-1958 to 8-18-1958 , that I last saw the deceased alive on 8-18-1958 , and that death occurred at 6:00 PM , from the causes and on the date stated above. ACTUAL SIGNATURE C. E. Pruitt		ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 8-19-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-1958		22c. NAME OF CEMETERY OR CREMATORIAL Mountain View	
22d. LOCATION (City, town, or county) Sharpsburg		(State) Maryland		22e. REC'D BY REGISTRAR DATE AUG 26 '58	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Fleet		ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9087

CERTIFICATE OF DEATH

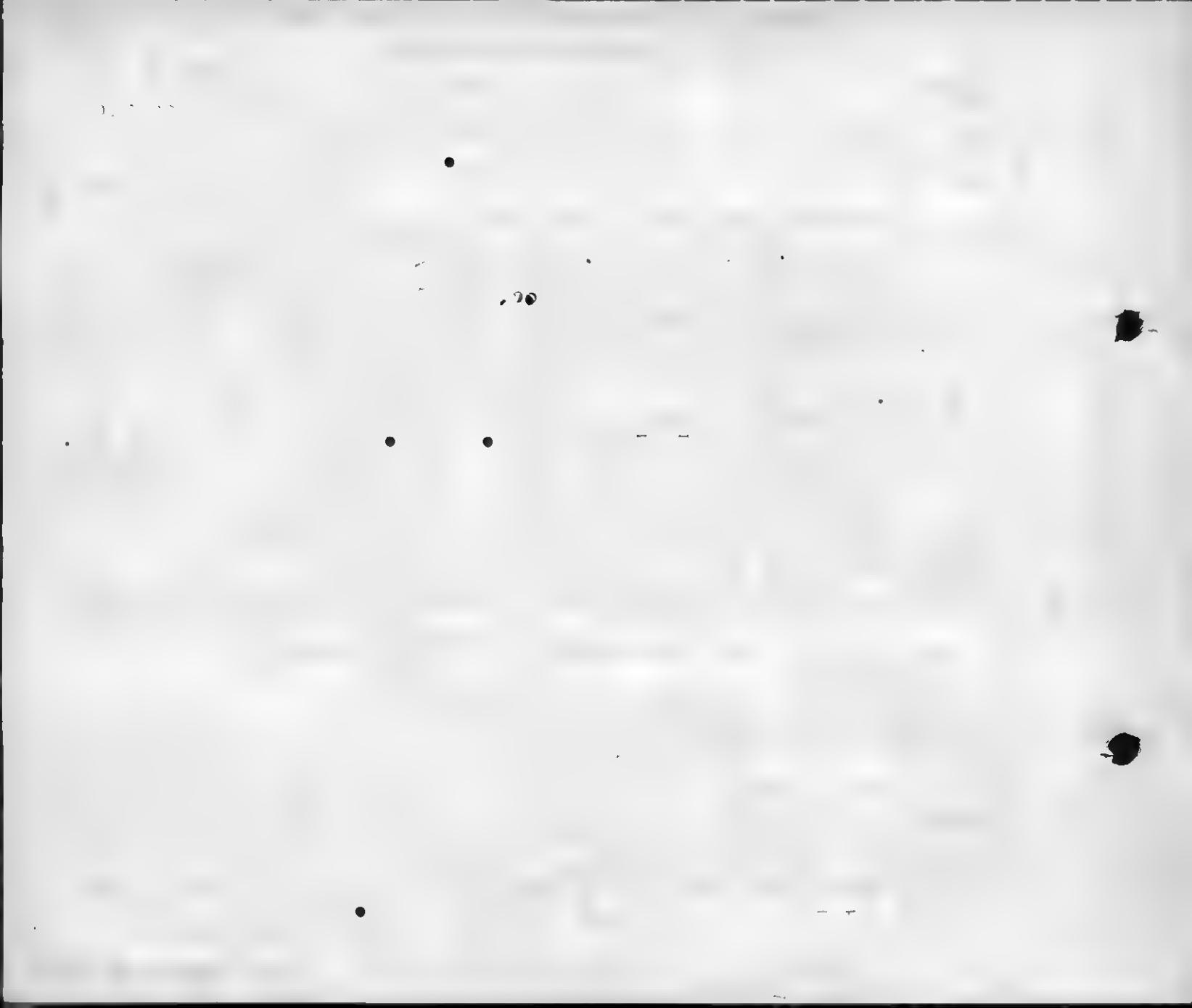
09071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodboro	c. LENGTH OF STAY IN 1b Several hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ERNEST-FLOYD- KEIHLHOLTZ	First	Middle	Last
4. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Livestock dealer	10b. KIND OF BUSINESS OR INDUSTRY Own business	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John D. Keiholtz	14. MOTHER'S MAIDEN NAME Anna Bell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 214-34-9778	17. INFORMANT Vernon Keiholtz	Address Fm itsburg, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO HCO.1		INTERVAL BETWEEN ONSET AND DEATH 2 minute	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 12 , 1954, to Aug. 5 , 1958, that I last saw the deceased alive on Aug. 5 , 1958, and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles R. Williams, M.D.		ADDRESS (Street, city or town, state) Emmitsburg, Md. 8/5/58	
PHYSICIAN'S NAME (Type) CHARLES R. WILLIAMS		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) C-8-58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Tabor Cemetery		22d. LOCATION (City, town, or county) Rocky Ridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond F. Crozier, Thurr nt, Maryland		ADDRESS	
		24a. REC'D BY REGISTRAR DATE AUG 11 '58	
		24b. REGISTRAR'S SIGNATURE Webb couch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and used as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9062

CERTIFICATE OF DEATH

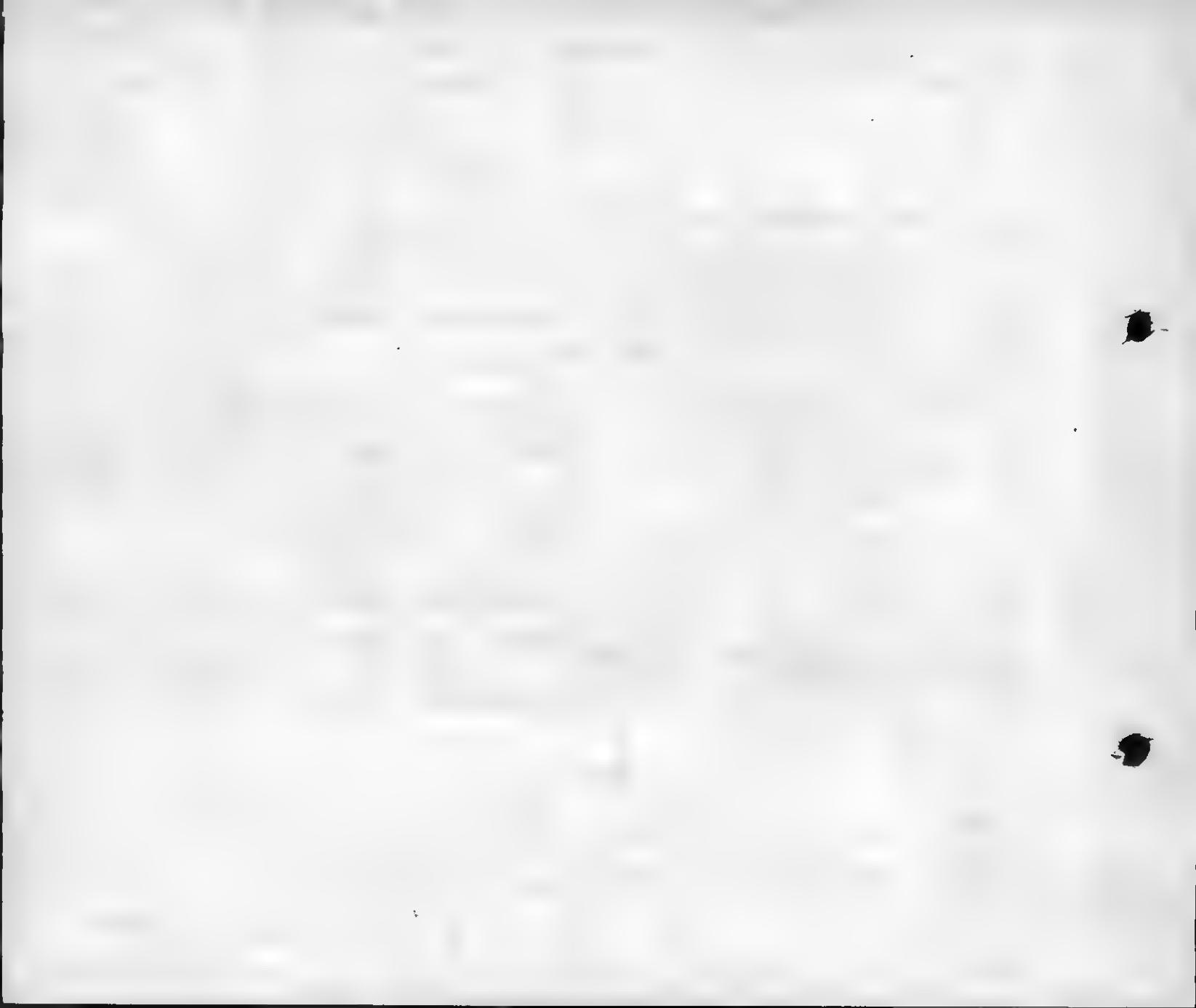
Reg. Dist. No.

09072

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A. This certificate has been signed by the attending physician and completely filled in by the funeral director. B. If this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK	c. LENGTH OF STAY IN 1b 1 DAY	b. COUNTY FREDERICK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X NEW MARKET		
3. NAME OF DECEASED (Type or print) M. John S Kelly	First M	Middle John S	Last Kelly
4. DATE OF DEATH Aug 14	Month Aug	Day 14	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-1878
9. AGE (In years last birthday) 80 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MERCHANT GROCERY	10b. KIND OF BUSINESS OR INDUSTRY GROCERY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES M. KELLY	14. MOTHER'S MAIDEN NAME EMMA SWOMLEY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT EVELYN KELLY	Address NEW MARKET MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Giantiplerotic Heart Disease (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frederick, Md	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 14 , 1958, to Aug 14 , 1958, that I last saw the deceased alive on Aug 14 , 1958, and that death occurred at 3:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick, Md			
ACTUAL SIGNATURE A. A. Pearre	DATE SIGNED 8/18/58		
PHYSICIAN'S NAME (Type) A. A. PEARRE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8-17-1958	22c. NAME OF CEMETERY OR CREMATORIUM MOUNT OLIVE CEM FREDERICK MD	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Falconer	ADDRESS New Market Md	24a. REC'D BY REGISTRAR DATE SEP 2 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9063

CERTIFICATE OF DEATH

69073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Md.	c. LENGTH OF STAY IN lb 20 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 315 Grove Blvd.	

3. NAME OF DECEASED (Type or print)	First C	Middle Walter	Last Kleist	4. DATE OF DEATH Aug... 28	Month Year 1958
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 25, 1891	9. AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Accountant	10b. KIND OF BUSINESS OR INDUSTRY Public Accountant	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Charles J. Kleist	14. MOTHER'S MAIDEN NAME Anna Johnson
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk	16. SOCIAL SECURITY NO 214-10-5289	17. INFORMANT Mrs. Grace Kleist (Wife) 315 Grove Blvd, City	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO <i>Carcinoma of stomach with metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)	INTERVAL BETWEEN ONSET AND DEATH 8 mo
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from <u>8-21-</u> , 19 <u>58</u> , to <u>8-28-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-27-</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>35 Church Frederick, Md.</i>				
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ACTUAL SIGNATURE <i>Rex R. Martin</i>	DATE SIGNED 8-26-58
PHYSICIAN'S NAME (Type) REX R. MARTIN, M.D.	35, East Church St. Frederick, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 30, '58	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Rex R. Martin</i>	1201 W. Market St. Fred. DAILEY'S FUNERAL HOME.	24a. REC'D BY REGISTRAR F.D. DATE SEP 2 '58	24b. REGISTRAR'S SIGNATURE <i>C. Wm. S. Kraus</i>
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69074

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PAG3. Postage may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-troull permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



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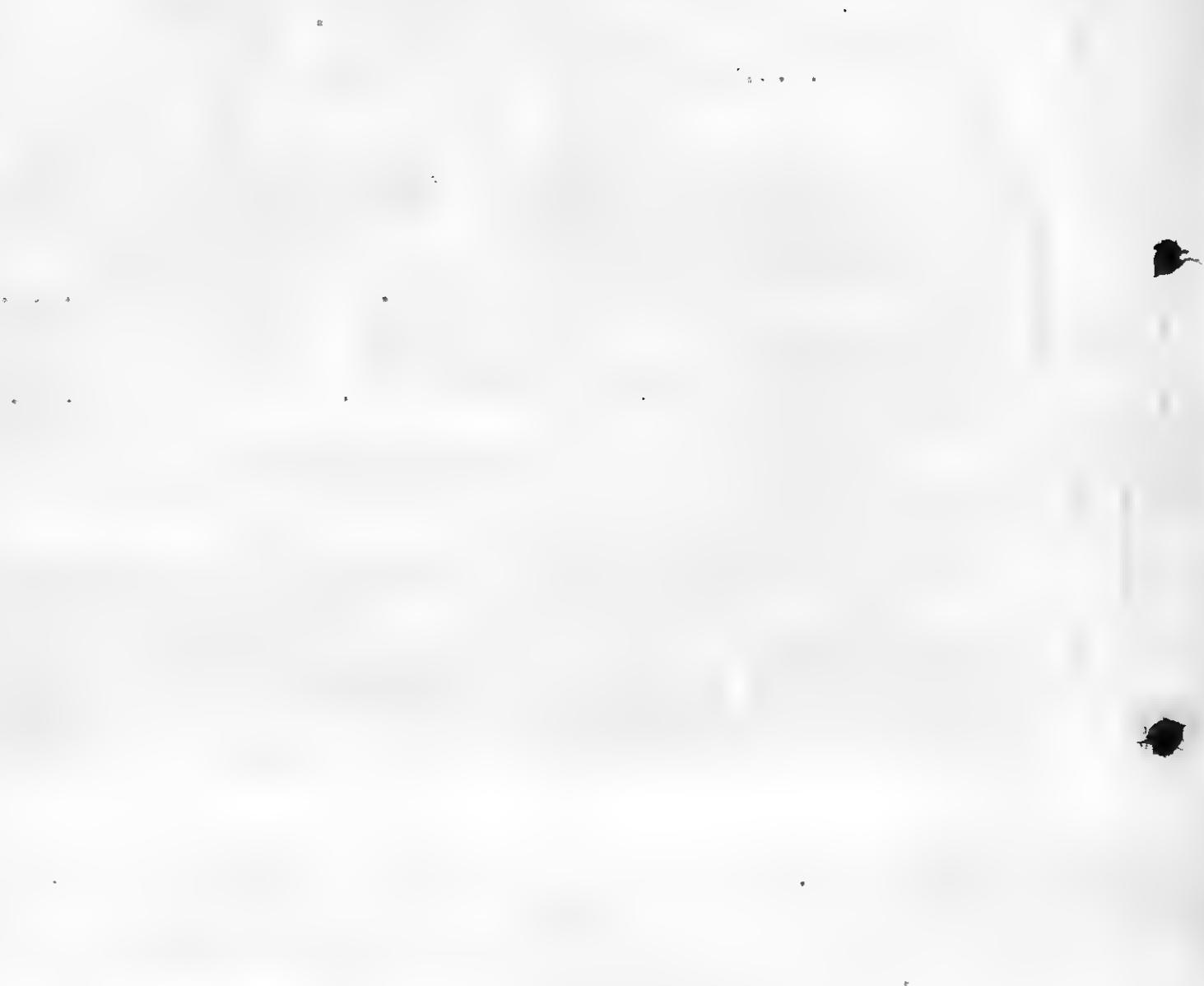
2

V.S. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9088 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick R.F.D.2		c. LENGTH OF STAY IN 1b 4		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Fla.		b. COUNTY Bellglade, Palm Beach	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)									
3. NAME OF DECEASED (Type or print)		First Henry		Middle Lewis		Last August 16		4. DATE OF DEATH	
5. SEX Male		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1899		9. AGE (In years at birthday) 59 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Fla.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Jenkins Bros. Records		Address Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Cerebral hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 20 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Ashburn		(County) (State) Georgia	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 18, 1958	
EXAMINER'S NAME (Type) B. O. Thomas		22b. DATE THEREOF 8-19-58		22c. NAME OF CEMETERY OR CREMATORIY Unknown		22d. LOCATION (City, town, or county) Ashburn Georgia		(State)	
22e. BURIAL, CREMATION REMOVAL (Specify) Remove1		22f. REC'D BY REGISTRAR Charles E. Hicks III Frederick, Maryland		22g. REGISTRAR'S SIGNATURE August 20 '58					
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III Frederick, Maryland		ADDRESS							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09676

9064

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
FREDERICK				a. STATE	b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		Md			
FREDERICK		4 dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		11 FREDERICK			
FREDERICK Memorial		507 E. CHURCH ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		1st	Middle	Last	4. DATE OF DEATH		
B				GIRL Matthews	Month Day Year August 8 1958		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
F		W		4 Aug 58	10	27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Infant		Infant		Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
James Paul Dickerson		Jeanne Elizabeth Matthews					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
		None		Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Sclerema				2 dys	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)					
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Atelectasis, neonatorum				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Doy.	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from		4 Aug 1958, to 8 Aug 1958				DATE SIGNED	
alive on		8 Aug 1958, and that death occurred at 2:30PM, from the causes and on the date stated above.				8/9/58	
ACTUAL SIGNATURE		R. L. Guest M.D.				ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		R. L. Guest				Frederick, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Burial		Aug. 9, 1958		Mount Olivet Cemetery		Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
M. R. Etchison & Son, Frederick, Maryland				AUG 12 1958		Arthur J. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is valid for 72 hours after death. Please remove carbon papers. Page 3 should be detached or use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9089

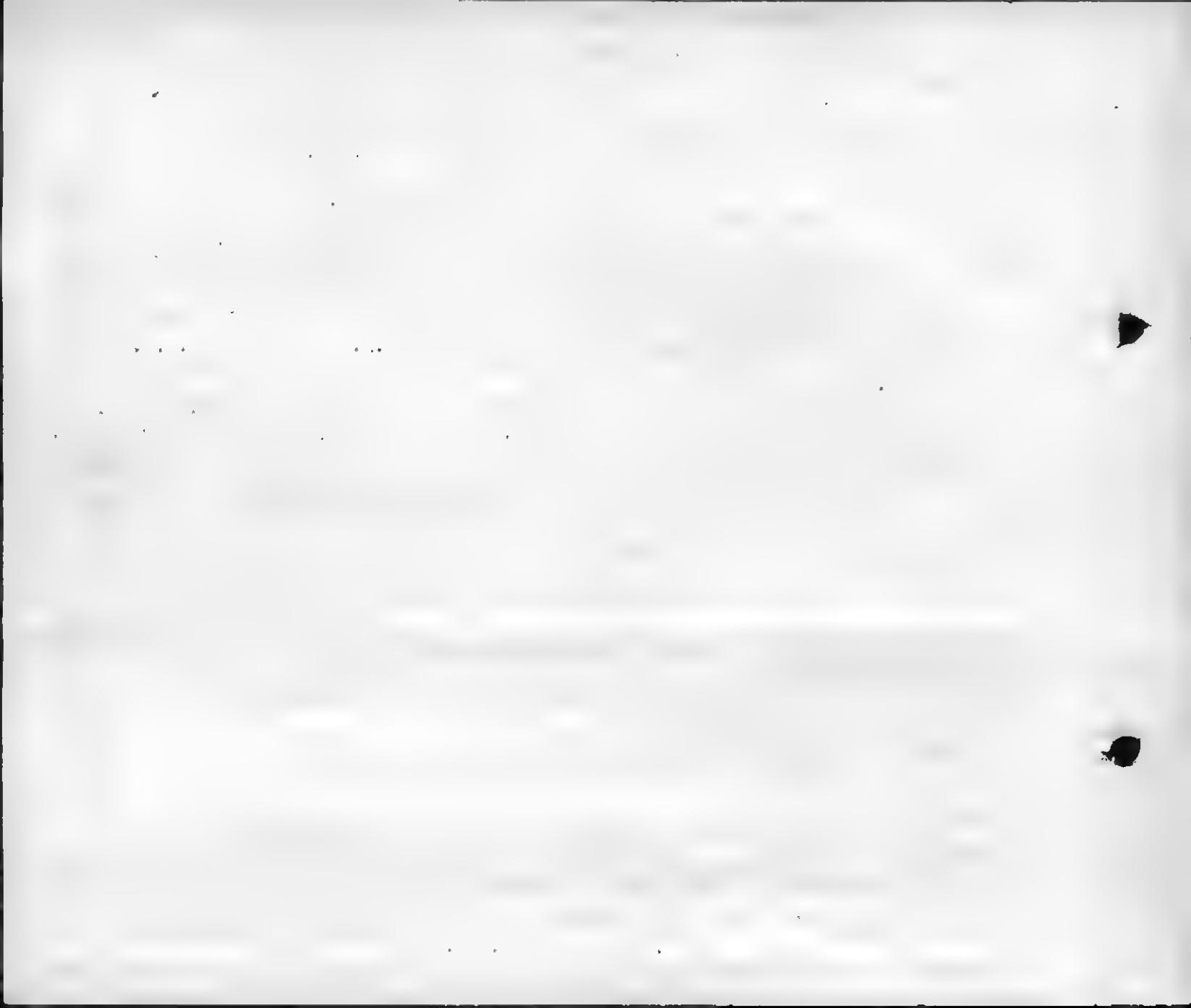
CERTIFICATE OF DEATH

69075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALKERSVILLE	c. LENGTH OF STAY IN 1b 12 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None	e. STREET ADDRESS 7 Maryland Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle PATRICK	Last McEWEN
4. DATE OF DEATH	Month August	Day 17	Year 1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1886
9. AGE (In years lost birthday) 72 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Brooklyn N.Y.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John D. McEwen		14. MOTHER'S MAIDEN NAME Mary Oatis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 065-01-7032	
17. INFORMANT Mrs. Paul Ganley, (Daughter) Frederick, Md.		Address W. 9th St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ 8/15, 1958 to _____ 8/17, 1958, that I last saw the deceased alive on _____ 8/17, 1958, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Physician's NAME (Type)	James B. Thomas, M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 20, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Frederick Memorial Park	22d. LOCATION (City, town, or county) Frederick, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Ganley, Jr.	ADDRESS 1201 N. Market, Fred. M.	24a. REC'D BY REGISTRAR DATE AUG 21 '58	24b. REGISTRAR'S SIGNATURE C. Lynn & Thrush

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
 Page 3 should be detached if used as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

69077

9090

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg		d. STREET ADDRESS 119 West Main Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 West Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Edwin	Middle Franklin	Last Ohler	4. DATE OF DEATH	Month August	Day 31	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH February 27, 1870	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Selling		10b. KIND OF BUSINESS OR INDUSTRY auto. dealer		11. BIRTHPLACE (State or foreign country) Frederick Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel G. Ohler				14. MOTHER'S MAIDEN NAME Susan Adeline Rowe					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-14-6073		17. INFORMANT Aimee O. Smith, Blue Ridge Summit, Pa.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
INTERVAL BETWEEN ONSET AND DEATH 15 years									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 30 W. Main St.		(County) Emmitsburg		(State) Maryland	
21. I certify that I attended the deceased from Aug 31 , 19 58 , to Aug 31 , 19 58 , that I last saw the deceased alive on Aug 31 , 19 58 , and that death occurred at Emmitsburg, Md. from the causes and on the date stated above.									
ACTUAL SIGNATURE W. R. Cadle		ADDRESS (Street, city or town, state) Emmitsburg, Md. DATE SIGNED Aug 31, 1958							
PHYSICIAN'S NAME (Type) W. R. Cadle		Emmitsburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-2-158		22c. NAME OF CEMETERY OR CREMATORIAL Bethel Lutheran		22d. LOCATION (City, town, or county) Emmitsburg, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE L. L. Allison Fairchild, Jr.		ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR SEP 3 '58		24b. REGISTRAR'S SIGNATURE Albert S. Knapp			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9065

CERTIFICATE OF DEATH

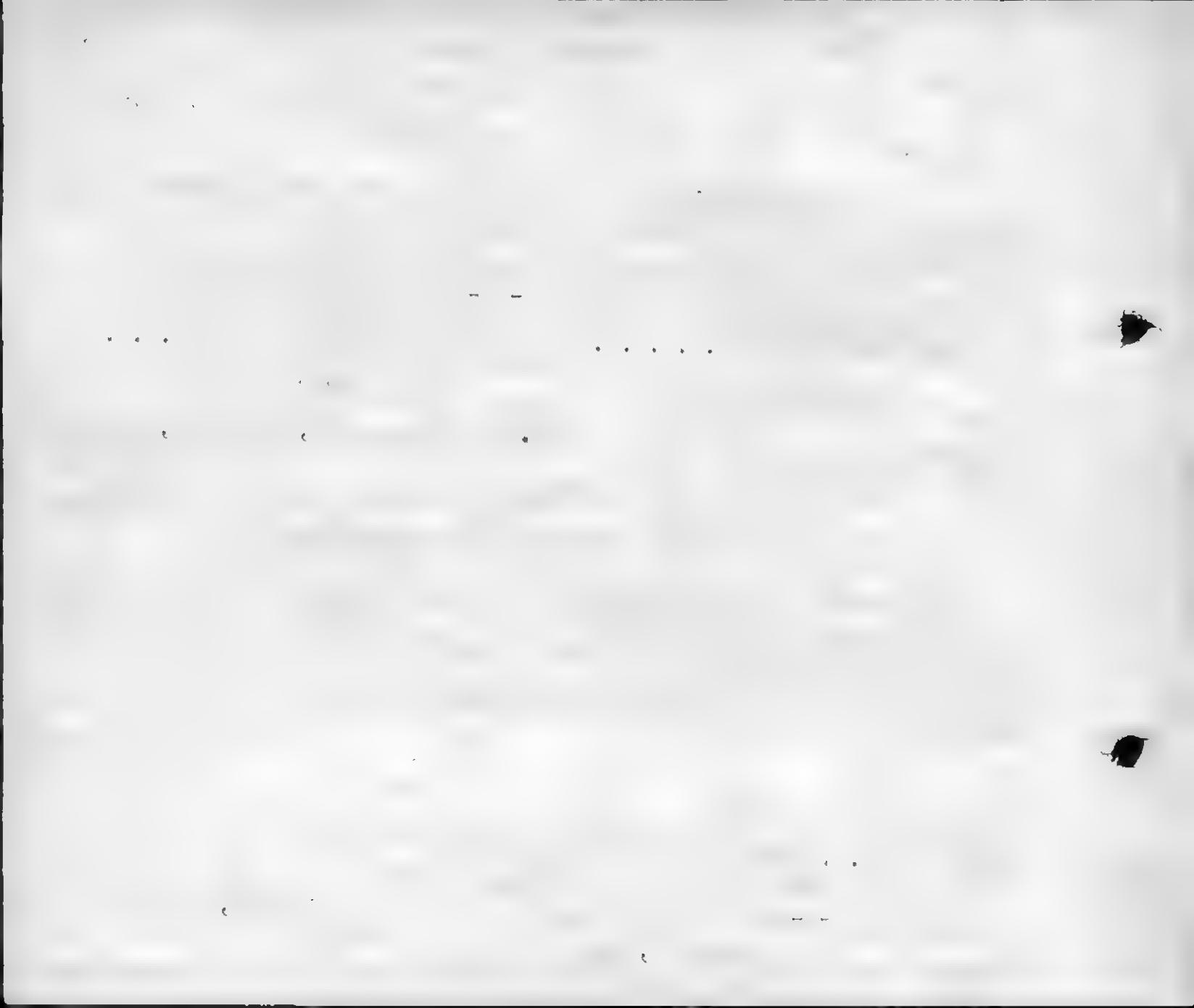
69078

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
Frederick MARYLAND		o. STATE <input checked="" type="checkbox"/> Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS 6 North Maryland Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>M. Hanson</i>	4. DATE OF DEATH <i>Aug 1, 1958</i>	Month	Day		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-1880		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BRAKEMAN	10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edward Orrison	14. MOTHER'S MAIDEN NAME Gertrude Marlow				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO	17. INFORMANT Mrs. Louella Orrison, Brunswick, Maryland	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Arteriosclerotic Heart Disease</i>					
DUE TO (b) <i>Embolus Iliac Artery</i> 10 days					
DUE TO (c) <i>Diabetes Mellitus</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ 19 p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____	(County)	(State)
21. I certify that I attended the deceased from <i>July 31, 1958</i> , to <i>Aug 1, 1958</i> , that I last saw the deceased alive on <i>Aug 1, 1958</i> , and that death occurred at <i>11:30 PM</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>A. A. Pearce</i>	M.D.			ADDRESS (Street, city or town, state) <i>Baltimore, Md.</i>	DATE SIGNED <i>8/1/58</i>
PHYSICIAN'S NAME (Type) A. A. Pearce					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-1-1958	22c. NAME OF CEMETERY OR CREMATORIAL Reformed	22d. LOCATION (City, town, or county) Middletown, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Lee Feeto</i>	ADDRESS Brunswick, Maryland	24a. REC'D BY REGISTRAR DATE AUG 7 '58	24b. REGISTRAR'S SIGNATURE <i>Alt. Leach</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9066

CERTIFICATE OF DEATH

09079

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick MARYLAND		o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b Over 60 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 512 North Market Street		d. STREET ADDRESS 512 North Market Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Cornelia	Middle Dora	Last Phillips
4. DATE OF DEATH	Month August	Doy 27	Year 19 58
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 5-1884
9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Jackson		14. MOTHER'S MAIDEN NAME Sarah (Don't. Know)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT		Address	
Mrs. Carl Biddinger-512 N. Market St.-Frederick-		Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Hypertensive arteriosclerotic vascular disease 7 yrs	
(b) Sensitivity DUE TO (c)		10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-1-1956, to 8-27-1958, that I last saw the deceased alive on 8-22-1958, and that death occurred at 2:45 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Rex R. Martin M.D. ADDRESS (Street, city or town, state) 35 E Church Street - Frederick, Maryland DATE SIGNED 8-28-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-30-1958	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son W.		24a. REC'D BY REGISTRAR DATE AUG 29 '58	
ADDRESS Frederick-Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9091

CERTIFICATE OF DEATH

69080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Mt. Airy		c. LENGTH OF STAY IN 1b 25 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Mt. Airy			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Mapleville		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First SAMUEL	Middle MARCELLUS	Last POOLE	4. DATE OF DEATH	Month Aug.	Day 28	Year 19 58
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-14-1869	9. AGE (In years less birthday) 88 yrs.	IF UNDER 1 YEAR Months 88	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (retired)		10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Henry Poole		14. MOTHER'S MAIDEN NAME Katie Mealy					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. W.G. Norris, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) DUE TO (c)		Myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH 48 hours	
		Coronary thrombosis				72 hours	
		Arteriosclerotic cardiovascular disease				10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 26 Aug. , 1958, to 28 Aug. , 1958, that I last saw the deceased alive on 25 Aug. , 1958, and that death occurred at 6:30 PM , from the causes and on the date stated above.				ADDRESS (Street, city, town, state) Walperville, Md.		DATE SIGNED 8/29/58	
ACTUAL SIGNATURE <i>James E. Stoner</i>		M.D.					
PHYSICIAN'S NAME (Type) JAMES E. STONER, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-31-1958		22c. NAME OF CEMETERY OR Crematory Linganore		22d. LOCATION (City, town, or county) Unionville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE 8/2 '58		24b. REGISTRAR'S SIGNATURE O'Brien & Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 4 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

Item 20 Film 25 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9067 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69081

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 15 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 608 Trail Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First NELSON	Middle HOLLINGER	Last REIFSNIDER	4. DATE OF DEATH August 30, 1958	Month August	Day 30	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 27, 1880	9. AGE (in years at birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miller		10b. KIND OF BUSINESS OR INDUSTRY Grain & Feed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel David Reifsnider		14. MOTHER'S MAIDEN NAME Sarah Alberta Hollinger							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-7947		17. INFORMANT Mr. N. Donovan Reifsnider, Frederick, Maryland		1703 Rosemont Avenue,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE SUB-DURAL HEMORRHAGE						INTERVAL BETWEEN ONSET AND DEATH 15 Days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 900.0		DUE TO (b)							
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell Down Flight of Stairs							
20c. TIME OF INJURY Hour 8/15/5819		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Frederick		(County) Frederick	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. B. O. Thomas	<i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/31/58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 2, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR SEP 3 '58		24b. REGISTRAR'S SIGNATURE <i>C. W. S. Kraus</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

69082

9092

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Doubs		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Doubs		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First IRENE	Middle HARDY	Last RUST	4. DATE OF DEATH	Month August	Day 16,	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 9, 1892		9. AGE (in years from birth) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John T. Hardy				14. MOTHER'S MAIDEN NAME Melinda Matthews				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Kemper C. Rust-Same as Item #2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 11/24/58								
(b) DUE TO Generalized arteriosclerosis		(c) Hypertension & Chronic Nephritis		34 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Leesburg, Maryland		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 8, 1958 to Aug 16, 1958 that I last saw the deceased alive on Aug 16, 1958 , and that death occurred at 1:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jefferson, Maryland								
ACTUAL SIGNATURE A. T. Brice DATE SIGNED 8/17/58								
PHYSICIAN'S NAME (Type) Dr. A. T. Brice								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 19, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Union Cemetery		22d. LOCATION (City, town, or county) Leesburg, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR AUG 19 '58	24b. REGISTRAR'S SIGNATURE S. J. L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9711230-27-58 et

09083

9068

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

3 days

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

Frederick Memorial Hosp.

3. NAME OF
DECEASED
(Type or print)First
NormaMiddle
E.Last
Sanner4. DATE
OF
DEATH

August 19 1958

5. SEX

6. COLOR OR RACE

female

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9-11-1882

9. AGE (in years
last birthday)

75 78 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Thomas Davis

14. MOTHER'S MAIDEN NAME

Sidney Rudy

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

{ Yes, no, or unknown If yes, give war or dates of service}

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Roger F. Sanner, Jr.

Same

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.0 DUE TO

Conditions, if any, which

gave rise to immediate

cause (b), stating the under-

lying cause lost.

(c)

INTERVAL BETWEEN

ONSET AND DEATH

4 days

Arteriosclerotic Heart Disease

10 yrs t

Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

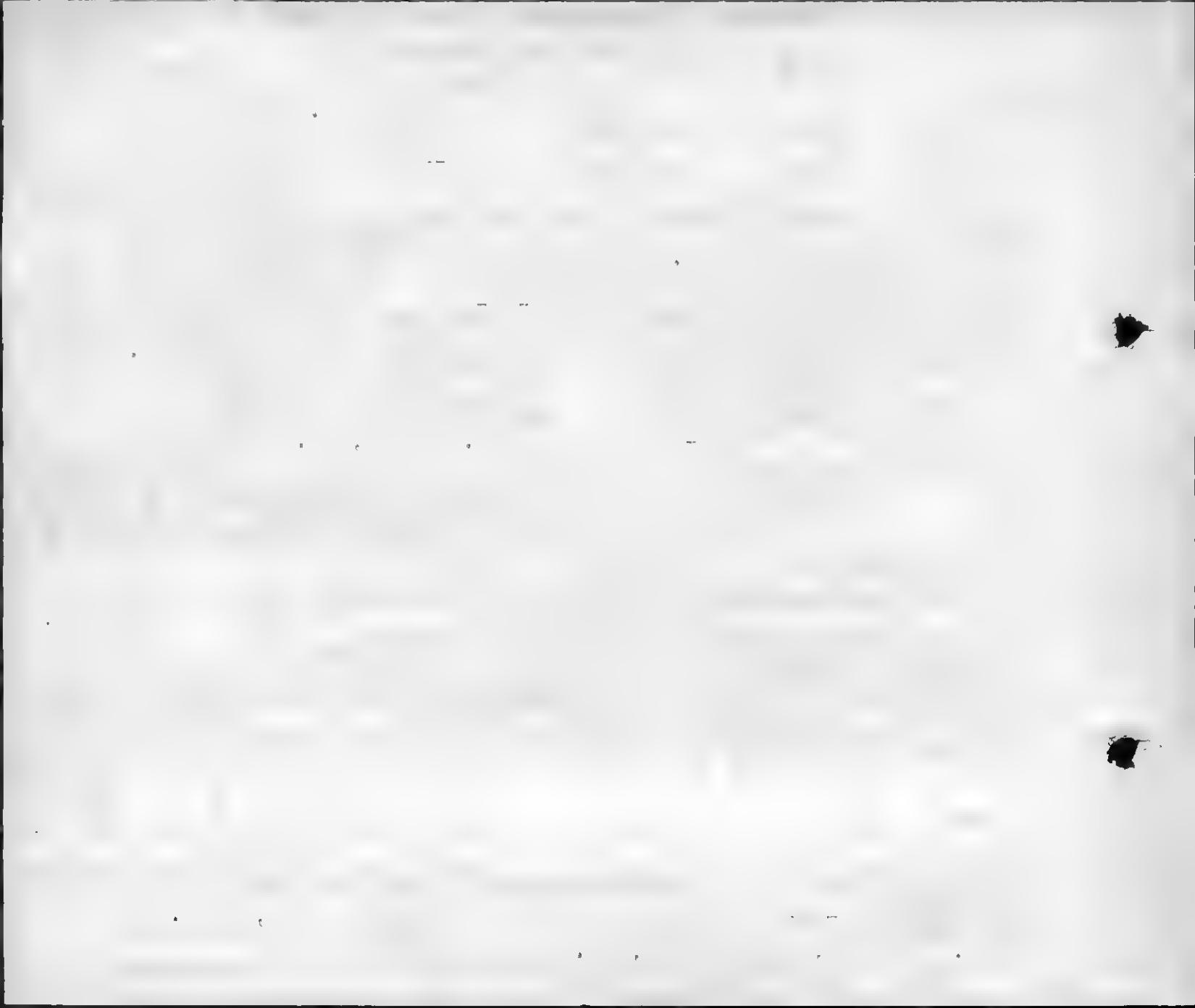
Chronic Lymphatic Leukemia

19. WAS AUTOPSY

PERFORMED?

YES NO

19. WAS AUTOPSY



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9069

CERTIFICATE OF DEATH

Reg. Dist. No.

69084

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN lb <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. airy</i>		d. STREET ADDRESS <i></i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: <i>Frederick Memorial Hospital</i>				d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>ELMER</i>	Middle <i>E.</i>	Last <i>SHAFER</i>	4. DATE OF DEATH <i>August 24 1958</i>	Month <i>Aug</i>	Day <i>24</i>	Year <i>1958</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>7-14-75</i>	9. AGE (In years last birthday) <i>83 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS Days <i></i>	Hours <i></i>	Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farm</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Mr. John Shafer</i>		14. MOTHER'S MAIDEN NAME <i>Gretta Keller</i>		Address <i></i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <i>none</i>		17. INFORMANT <i>Mrs. Francis Staley, Unionville, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe Enterocolitis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i>		
DUE TO <i>610X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i></i>		(b) DUE TO <i>Postoperative prostatectomy (Resection) 5 days</i>						
		(c) DUE TO <i>Hypertrophy + genitally ad- hesive adhesions</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Arterosclerotic Heart Disease, Arteriosclerotic Artery Disease</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>April 29, 1958</i> to <i>August 24 1958</i> that I last saw the deceased alive on <i>24 August 1958</i> , and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert D. Crouch</i>						ADDRESS (Street, city or town, state) <i>101 Frederick Shopping Center</i>		DATE SIGNED <i>8-24-58</i>
PHYSICIAN'S NAME (Type) <i>ROBERT D. CROUCH</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>8/27/1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Reformed Cemetery</i>		22d. LOCATION (City, town, or county) <i>Middletown</i>		(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gladhill Company, Middletown, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>SEP 2 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Haas</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

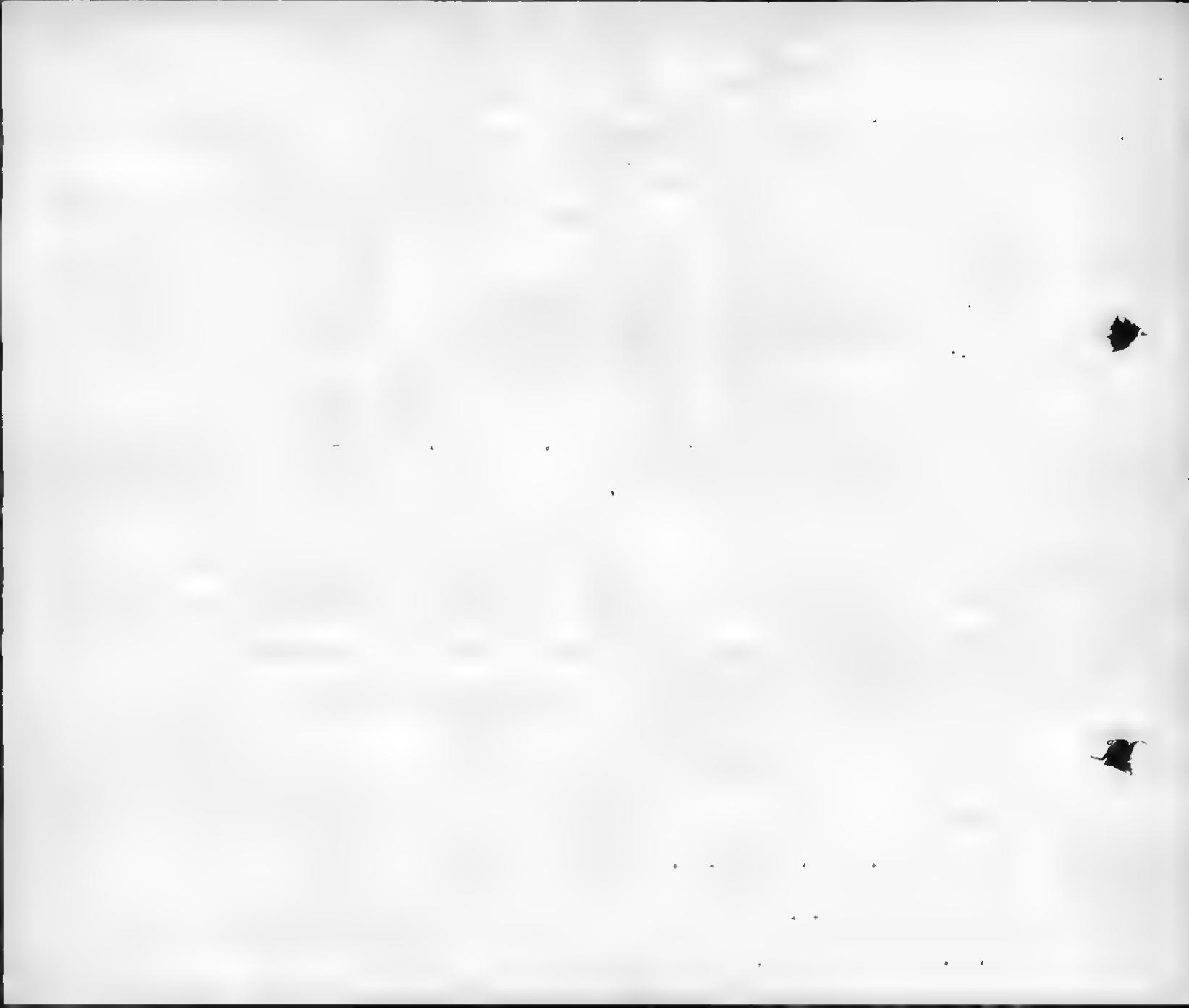
9070

CERTIFICATE OF DEATH

Reg. Dist. No.

69085

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 806 North Market Street		e. STREET ADDRESS 806 North Market Street	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LURENE Middle ALVIN Last STALEY		4. DATE OF DEATH Month August Day 30, Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1888
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Five & Dime Store	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Staley		14. MOTHER'S MAIDEN NAME Letha Zimmerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO 214-10-4539	
17. INFORMANT Mr. Roland B. Staley— Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 10, 1952, to Aug. 30, 1958, that I last saw the deceased alive on Dec. 15, 1955, and that death occurred at 3:50A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE 12. M.D. Professional Building DATE SIGNED 8/31/58			
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Jr.		Frederick, Maryland	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Cremation		22b. DATE THEREOF Sept. 2, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Crematory		22d. LOCATION (City, town, or county) Bladensburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE SEP 3 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09086

9071

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached or use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Frederick</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
<i>Rural</i>	<i>36 hrs.</i>	<i>Frederick</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
<i>Fred. Memorial Hospital</i>	<i>Woodsboro</i>		
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	<i>ARCHIE</i>	<i>M.</i>	<i>STIMMEL</i>
4. DATE OF DEATH	Month	Day	Year
	<i>August</i>	<i>17</i>	<i>1958</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>M</i>	<i>W</i>	<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>May 30, 1873</i>
9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
<i>85 yrs</i>	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Baseball Pitcher</i>	<i>Professional</i>	<i>Maryland</i>	<i>U.S.A.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Edward H. Stimmel</i>	<i>Mary Jane Barrick</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
<i>No</i>	<i>189-07-0692A</i>	<i>Mr. G. L. Cuthell, Woodsboro, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiovascular insumbore</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Interstitial Pneumonitis</i>			
DUE TO (c) <i>5 days</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>1. Hypertension</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>2. Falls</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
<i>Aug. 17 1958</i>		<i>19</i>	<i>Woodsboro</i>
21. I certify that I attended the deceased from <i>Aug. 17, 1958</i> , to <i>Aug. 17, 1958</i> , that I last saw the deceased alive on <i>Aug. 17, 1958</i> , and that death occurred at <i>4:00 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. A. Dettbarn</i>		ADDRESS (Street, city or town, state) <i>Walkersville, Md.</i>	
PHYSICIAN'S NAME (Type) <i>E. A. DETTBARN</i>		DATE SIGNED <i>Aug. 17, 1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/19/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Hope cemetery</i>
22d. LOCATION (City, town, or county) <i>Woodsboro</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Barton</i>		24a. REC'D BY REGISTRAR <i>AUG 20 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>
ADDRESS <i>Walkersville, Md.</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09087

9072

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 37 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 412 East Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR INSTITUTION 112 East Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle Henry Last Stone				4. DATE OF DEATH Month August Day 14 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 30-1895	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fibre man		10b. KIND OF BUSINESS OR INDUSTRY Brush Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis David Stone				14. MOTHER'S MAIDEN NAME Emma Virginia Blank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-2035		17. INFORMANT Mrs. Raymond H. Stone-412 East St.-Frederick-		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral-vascular accident</i> DUE TO (c) <i>Hypertension</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>Days</i>							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/15/1958</u> to <u>8/14/1958</u> , that I last saw the deceased alive on <u>8/13/1958</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Frederick, Maryland</i> DATE SIGNED <i>8/15/58</i>							
ACTUAL SIGNATURE <i>James B. Thomas</i>		PHYSICIAN'S NAME (Type) Dr. James Thomas					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 18-1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Tabor Cemetery		22d. LOCATION (City, town, or county) (State) Rocky Ridge- Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Cline & Son</i>		ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR AUG 18 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



1

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached and used as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

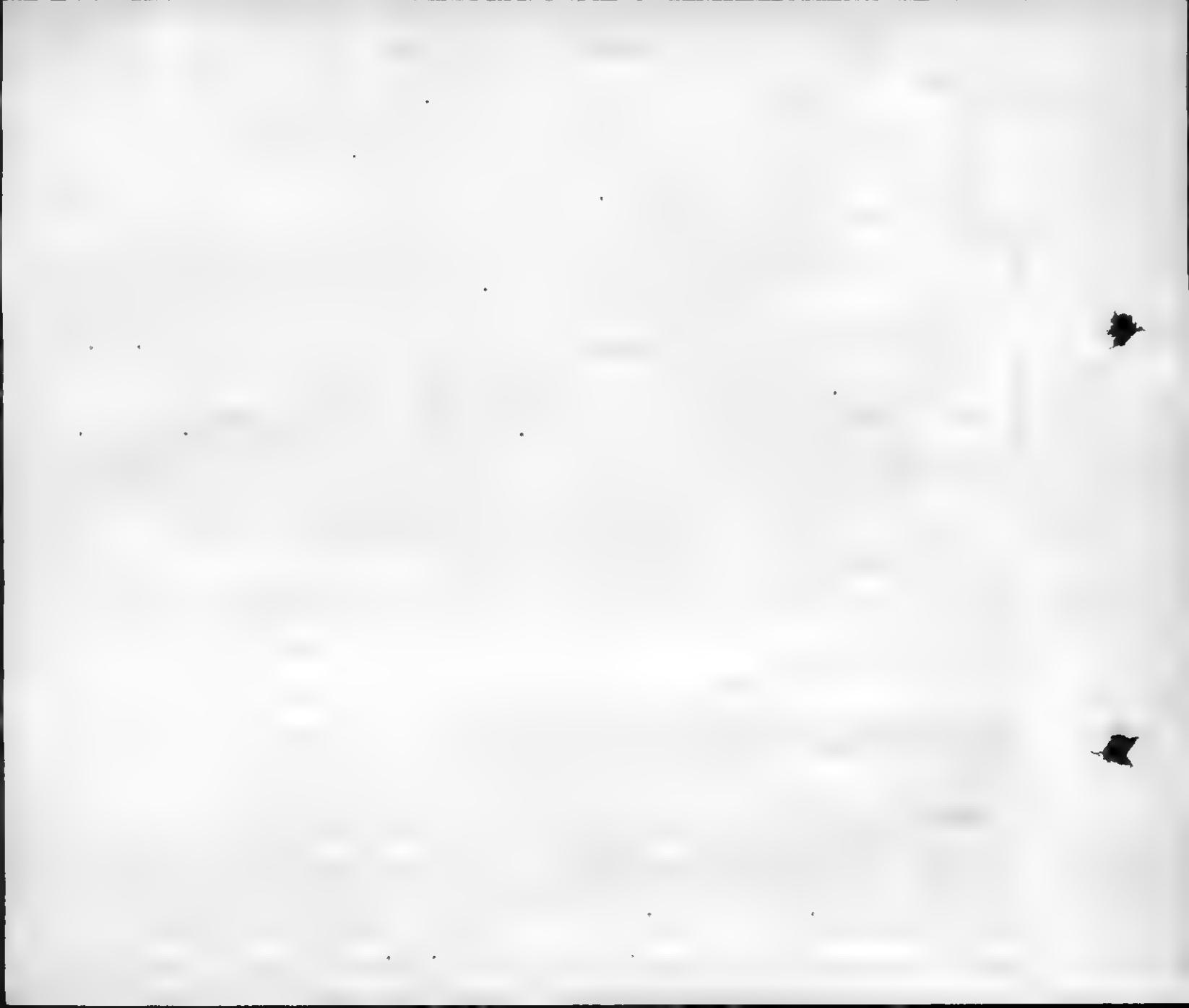
9073

CERTIFICATE OF DEATH

09088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick, Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		none 12 West 13th St.		d. STREET ADDRESS		12 West 13th St.		
3. NAME OF DECEASED (Type or print)		First GLENNA	Middle RHEA	Last STRINE	4. DATE OF DEATH	Month August	Day 21	Year 19 58
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1900	9. AGE (In years from birthday) 57 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME WILLIAM H. MILLER		14. MOTHER'S MAIDEN NAME CLARA FUSS						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, say, unknown) NO		16. SOCIAL SECURITY NO. 220-07-4817		17. INFORMANT Mr. Roy O Strine (Husband)		Address 12 W. 13th St.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Cirrhosis of liver				INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs		
		Infectious hepatitis				3-4 yrs		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 8-7-1958, to 8-21-1958, that I last saw the deceased alive on 8-19-1958, and that death occurred at 12:45 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 35 E Church Frederick 8-22-58		
ACTUAL SIGNATURE Rex R. Martin		M.D.				DATE SIGNED		
FICTITIOUS NAME (Type) Rex R. Martin								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 23, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hope Cemetery		22d. LOCATION (City, town, or county) Woodsboro, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert S. Kline		ADDRESS 1201 N. Market St. Fred		24a. REC'D BY REGISTRAR Mt. Hope Cemetery DATE AUG 25 '58		24b. REGISTRAR'S SIGNATURE Albert S. Krause		



1. **MEDICAL EXAMINER**. This certificate shall be executed within hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be used for your files.
 2. **TO FUNERAL DIRECTOR**. Item 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

69089

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9074 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Frederick</i> MARYLAND		a. STATE <i>Maryland</i>	b. COUNTY <i>Carroll</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Frederick</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>Frederick Memorial Hosp</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Clarence</i>	Middle <i>Woodson</i>
		Last <i>Stultz</i>	4. DATE OF DEATH <i>August 30</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>December 24, 1927</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>TRUCK DRIVER</i>	
10c. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
YES <i>Korean</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>THOMAS D. STULTZ</i>		14. MOTHER'S MAIDEN NAME <i>FANNIE GRIMES</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>220-22-3714</i>	
YES <i>Korean</i>		17. INFORMANT <i>THOMAS STULTZ</i>	
		Address <i>RURAL WESTMINSTER MD</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>57 days</i>	
<i>Fractured skull</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
<i>Fractured right thigh.</i>			
DUE TO (b)			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Head-on collision of two automobiles</i>	
20c. TIME OF INJURY Hour <i>9:25 a.m.</i> Month, Day, Year <i>8/30 1958</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Libertytown Frederick Md</i>		20f. (City or town) <i>Libertytown</i> (County) <i>Frederick</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>B. P. Thomas</i>		DATE SIGNED <i>8/30/58</i>	
EXAMINER'S NAME (Type) <i>B. P. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>9/1/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>SAMS CREEK</i>		22d. LOCATION (City, town, or county) <i>FREDERICK CO MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>D. Hartzler & Sons New Windsor MD</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 2 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9093 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

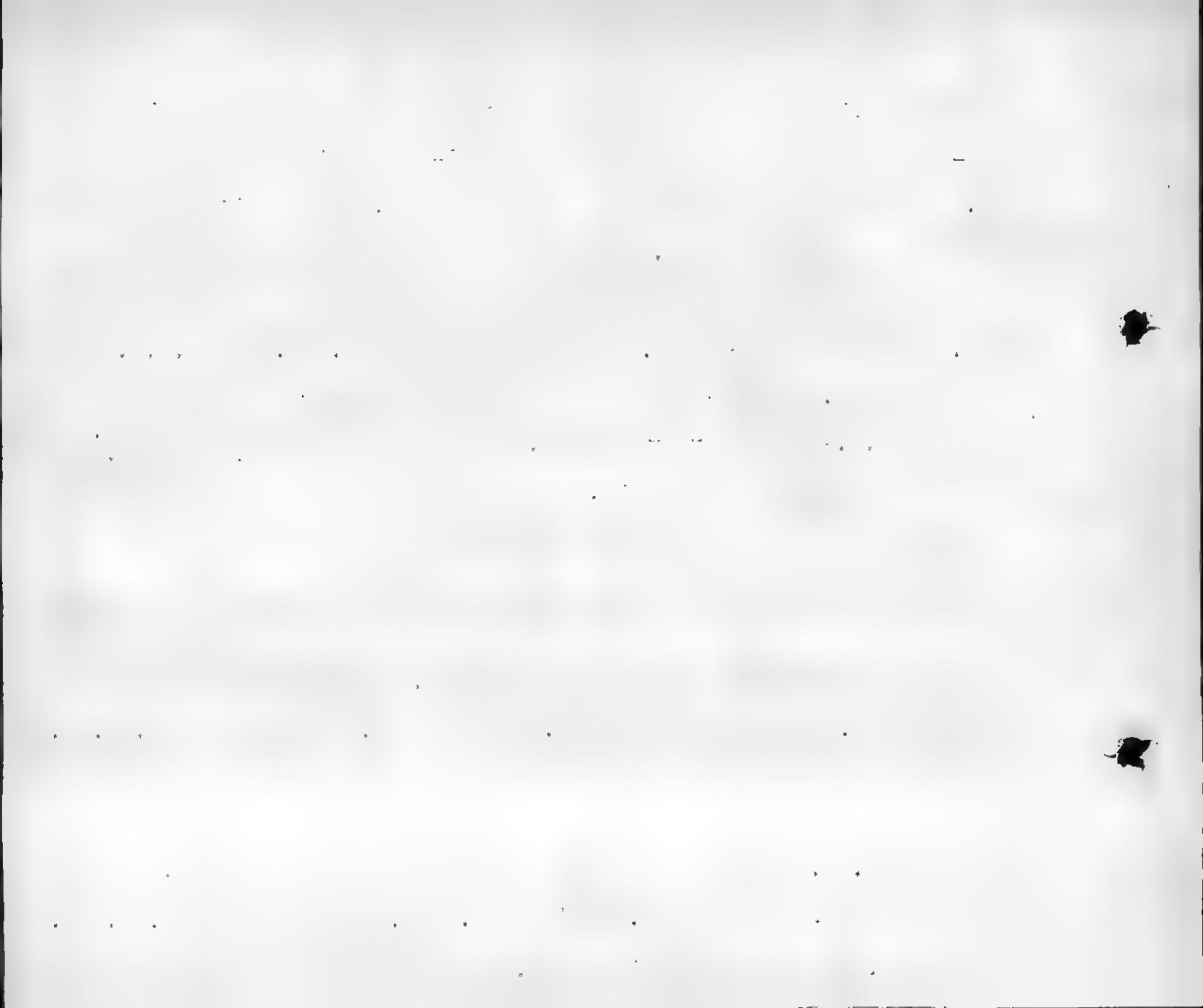
69090

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used as a burial-tranit permit. File Pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Rural-Myersville		b. COUNTY Frederick	
c. LENGTH OF STAY IN lb Instant		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Rural- Myersville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. #40 and Church Hill road		d. STREET ADDRESS Route # 1. Church Hill	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDGAR		First C.	Middle WARRENFELTZ
4. DATE OF DEATH August 23 1958	Month Day Year		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 17, 1894
9. AGE [In years less birthday] 64 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer	10b. KIND OF BUSINESS OR INDUSTRY Own Gen.Farm	11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Soula J. Warrenfetz		14. MOTHER'S MAIDEN NAME Clara Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] yes		16. SOCIAL SECURITY NO. W.W.# 1	17. INFORMANT 215-20-8527 Mrs. Dora Abdallah, 836 Virginia Ave., Hagerstown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chrushed Chest		INTERVAL BETWEEN ONSET AND DEATH instant	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 816X		(b)	
DUE TO Automobile Accident		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. auto struck by eastbound auto, Rt. #40 and Church Hill road		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) struck by eastbound auto, Rt. #40 and Church Hill road	
20c. TIME OF INJURY Hour 8:10 p. m.	Month, Day, Year Aug. 23 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Rt. # 40	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nr. Myersville, Fred. Co. Md.
20f. (City or town) Nr. Myersville, Fred. Co. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>B. O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Aug. 23, 1958
22a. BURIAL, CREMATION, REMOVAL [Specify] Burial	22b. DATE THEREOF Aug. 26, 1958	22c. NAME OF CEMETERY OR CREMATORIUM St. John's Luth.	22d. LOCATION (City, town, or county) Nr. Myersville, Fred. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul F. Bittle</i>	ADDRESS Myersville, Md.	24a. REC'D BY REGISTRAR AUG 26 1958	24b. REGISTRAR'S SIGNATURE <i>Paul F. Bittle</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

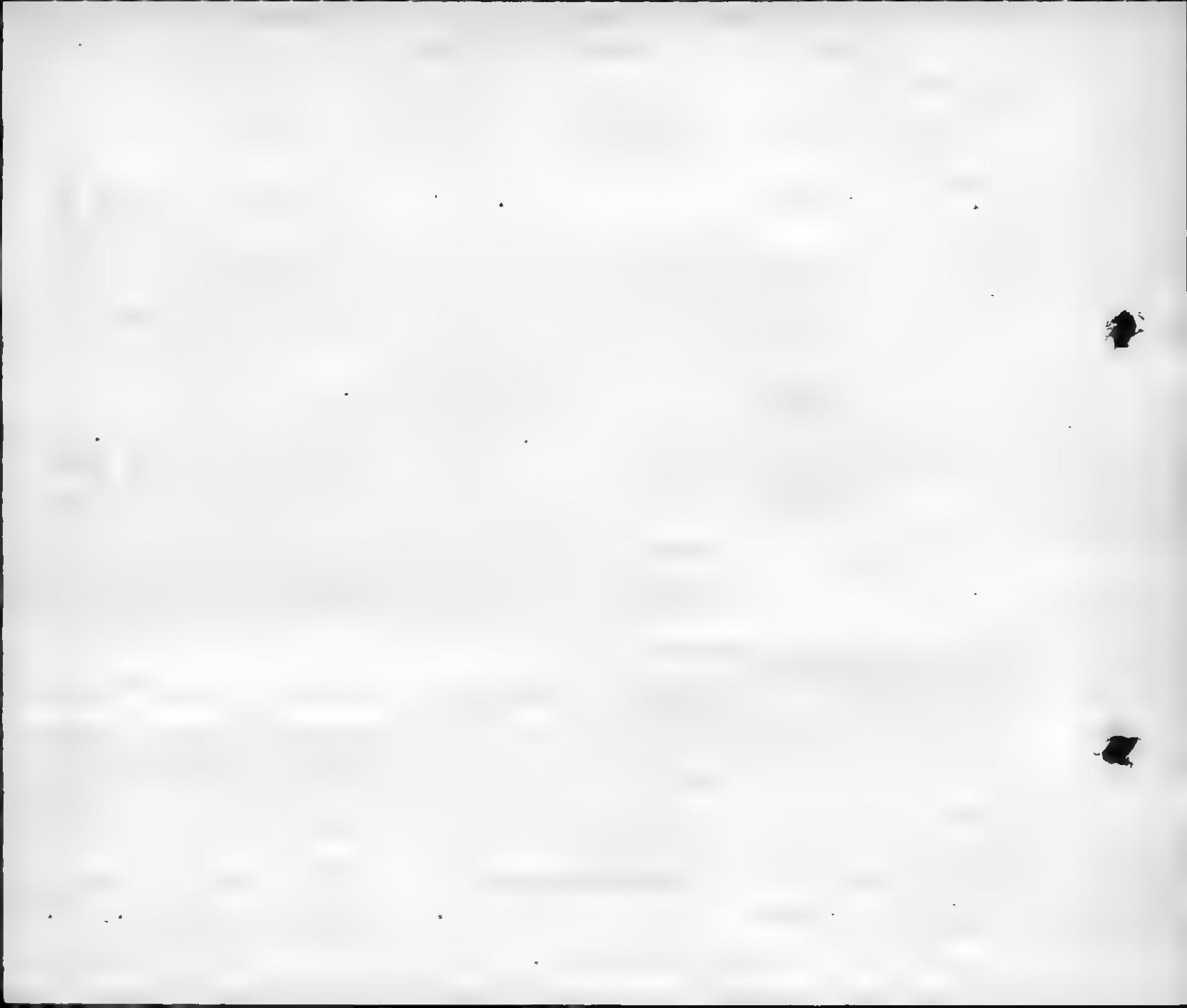
9094

CERTIFICATE OF DEATH

Reg. Dist. No.

69691

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Urbana	c. LENGTH OF STAY IN 1b 20 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Urbana	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 2 Frederick	e. STREET ADDRESS Rt. # 2 Frederick	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) Susie First Amanda Middle Webb Last	4. DATE OF DEATH Month August Day 22 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia
			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Obediah Fulcher		14. MOTHER'S MAIDEN NAME Elizabeth M. Fulcher (
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. no	17. INFORMANT H. Hyter webb Address Gaithersburg, Md. RFD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchitis - pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>severe Cardiac Dilatation</u> DUE TO (c) <u>with pulmonary edema</u> DUE TO			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 22, 1958</u> to <u>Aug 22, 1958</u> that I last saw the deceased alive on <u>Aug 22, 1958</u> , and that death occurred at <u>Laytonsville, Md.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B.C. Thomas</u>		ADDRESS (Street, city or town, state) <u>Laytonsville, Md.</u> DATE SIGNED <u>August 23, 1958</u>	
PHYSICIAN'S NAME (Type) <u>B.C. Thomas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-25-58	22c. NAME OF CEMETERY OR CREMATORIALaytonsville Meth.
22d. LOCATION (City, town, or county) Laytonsville, Mont., Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Royce Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	24a. REC'D BY REGISTRAR DATE AUG 26 '58
			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9075

Item 15 817-0232 R-1F-59 et

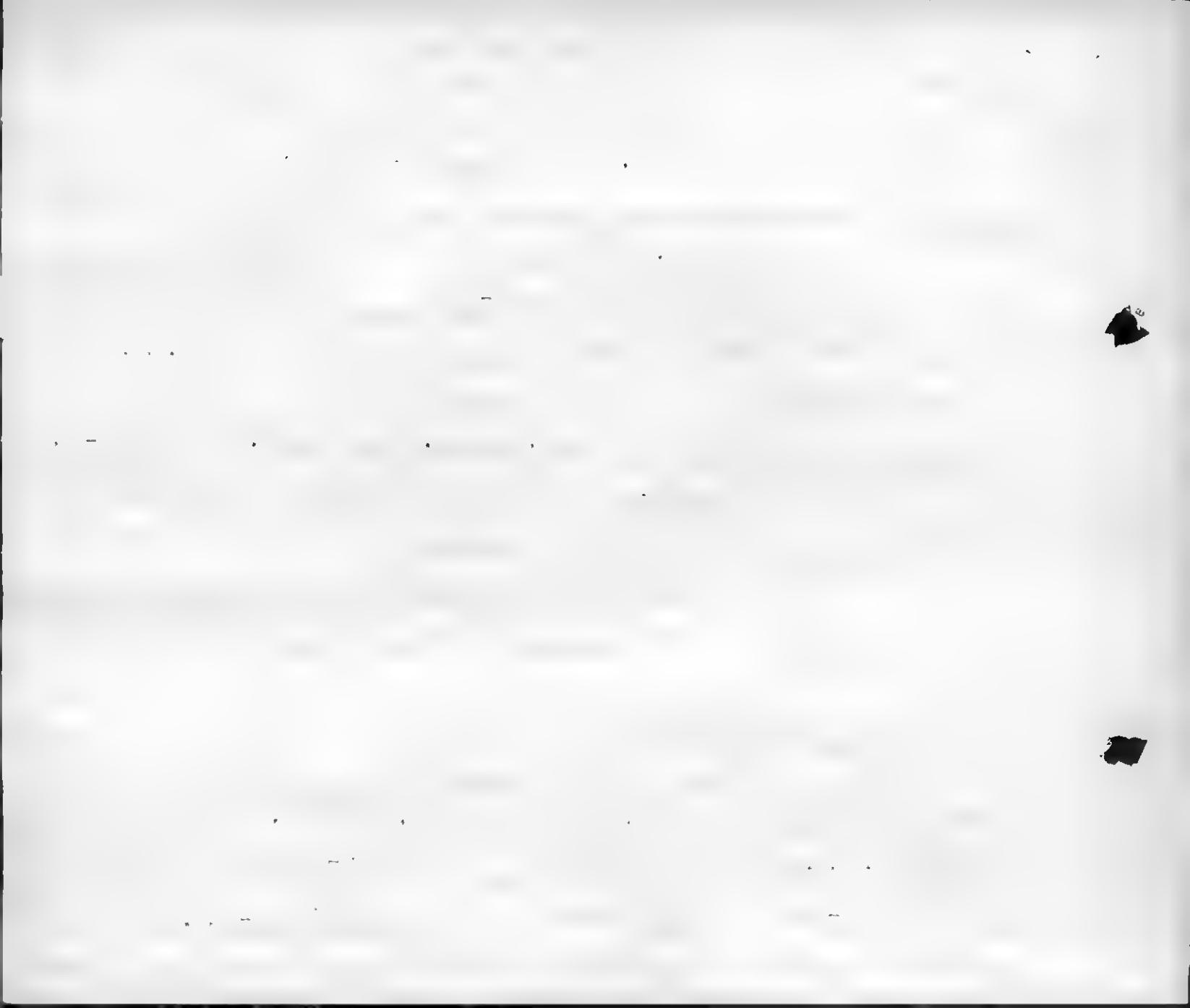
CERTIFICATE OF DEATH

Reg. Dist. No.

09092

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be reigned by the **H**ospital or attending physician.
TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and is to be filed with
 Page 3 should be detached for use of the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 4 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION /		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Frederick			
3. NAME OF DECEASED (Type or print) DAVID		First O.	Middle Weisburger		
4. DATE OF DEATH August 9th	Month Year 1958	5. SEX Male	6. COLOR OR RACE White		
7. MARRIED Never married	8. DATE OF BIRTH 4-15-1892	9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 0		
11. IF UNDER 24 HRS. Days 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Anson Weisburger	14. MOTHER'S MAIDEN NAME Fannie Vogel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WWar I 100-26-6312	17. INFORMANT Mrs. David O. Weisburger-Rt. 5- Frederick-Md.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior-lateral Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491.9 Bronchopneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 491.9 Bronchopneumonia				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4 E. Church St.	20f. (City or town) Frederick	(County) Maryland	(State) MD
21. I certify that I attended the deceased from 12/22 , 1956, to 8/9 , 1958, that I last saw the deceased alive on 8/8 , 1958, and that death occurred at 12:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Henry V. Chase PHYSICIAN'S NAME (Type) Dr. H.V. Chase					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 8-11-1958	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Lee Crematory	22d. LOCATION (City, town, or county) Washington, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son	24a. REC'D BY REGISTRAR Aug 11 1958	24b. REGISTRAR'S SIGNATURE W. E. Cline	DATE 8-11-1958		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9095

CERTIFICATE OF DEATH

Reg. Dist. No. 69093

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALKERSVILLE		c. LENGTH OF STAY IN lb 50 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FULTON AVE,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALKERSVILLE	
3. NAME OF DECEASED (Type or print) FANNIE		First MAY	Middle L
4. DATE OF DEATH AUG 31st 1958		Month AUG	Day 31st
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JAN 30- 1868		9. AGE (in years last birthday) 90 yrs.	10. IF UNDER 1 YEAR Months 0
11. BIRTHPLACE (State or foreign country) MARYLAND		12. IF UNDER 24 HRS. Days 0	13. IF UNDER 24 HRS. Hours 0
14. CITIZEN OF WHAT COUNTRY? U.S.A		15. FATHER'S NAME GEORGE FITEZ	
16. SOCIAL SECURITY NO. 0)		17. INFORMANT MRS HELLEN REIGHTLER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week Cerebral thrombosis Hypertension, generalized 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 19 58 , to 31 August 1958 , that I last saw the deceased alive on 31 August 1958 , and that death occurred at 8:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James E. Stoner Jr.</i>		ADDRESS (Street, city or town, state) Walkersville, Md 2 Sept 58	
PHYSICIAN'S NAME (Type) JAMES E. STONER Jr.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 2-1958	
22c. NAME OF CEMETERY OR CREMATORIUM MT HOPE		22d. LOCATION (City, town, or county) WOODSBORO (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Barton</i>		24a. REC'D BY REGISTRAR DATE SEP 3 '58	
ADDRESS WALKERSVILLE MD		24b. REGISTRAR'S SIGNATURE <i>James S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9096

CERTIFICATE OF DEATH

Reg. Dist. No.

09694

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Frederick</i>				a. STATE	<i>Maryland</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	<i>Frederick</i>
<i>Rural - Mt Airy</i>		<i>6 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	<i>Rural - Mt Airy</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<i>Penn Shop Road</i>		<i>Penn Shop Rd.</i>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
<i>Jenkins</i>			<i>Fannie Norri</i>	<i>August 26</i>	<i>1958</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
<i>Female</i>	<i>Colored</i>	<i>WIDOWED <input checked="" type="checkbox"/></i>	<i>4-30-1887</i>	<i>71</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>housewife</i>				<i>Maryland</i>	
13. FATHER'S NAME		14. MOTHER'S MÄDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<i>Clinton Biggus</i>		<i>Isabelle Thomas</i>		<i>U.S.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
<i>No</i>		<i>none</i>		<i>Mrs. Anna M. Dotson, Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Carcinoma of Breast.</i>			
170X		7 years			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I attended the deceased from <i>June</i> , 19 <i>58</i> , to <i>—</i> , 19 <i>—</i> , that I last saw the deceased alive on <i>June —</i> , 19 <i>58</i> , and that death occurred at <i>11:35 P.M.</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE	<i>W.B. Culwell</i>		M.D.	<i>Mt Airy, Md</i>	
PHYSICIAN'S NAME (Type)	<i>W.B. Culwell</i>			8/27/58	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF		22c. NAME OF CEMETERY OR CINCERATOR	22d. LOCATION (City, town, or county) (State)	
<i>BURIAL</i>	<i>8-30-1958</i>		<i>John Wesley</i>	<i>Libertytown, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE	
<i>C. M. Waltz,</i>	<i>Winfield, Md.</i>		<i>AUG 29 '58</i>	<i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF SOUTH DAKOTA

CERTIFICATE OF DEATH

NAME OF DECEASED John Doe	SEX Male	AGE 65 years
ADDRESS 123 Main Street	PLACE OF DEATH Hospital	TIME OF DEATH 10:00 AM
DATE OF BIRTH 1930	CAUSE OF DEATH Heart Disease	DEATH CERTIFIED By Doctor
DEATH CERTIFIED By Doctor	Signature of Doctor Dr. John Doe	Signature of Hospital Administrator
This certificate is issued under the laws of the State of South Dakota.		
Date: October 10, 1995		